DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K8T1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00749

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245261**

2.STATE VENDOR OR MEDICAID NO.
(L2) **484243000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOOD DALE HOME INC**
(L4) **600 SUNRISE BOULEVARD**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/06/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Koch, HFE NE-II 06/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske, Enforcement Specialist 66/11/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245261

June 11, 2018

Ms. Judith Sandmann, Administrator
Wood Dale Home Inc
600 Sunrise Boulevard
Redwood Falls, MN 56283

Dear Ms. Sandmann:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 7, 2018 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 11, 2018

Ms. Judith Sandmann, Administrator
Wood Dale Home Inc.
600 Sunrise Boulevard
Redwood Falls, MN 56283

RE: Project Number S5261028

Dear Ms. Sandmann:

On April 16, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 29, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 11, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 7, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 29, 2018, effective May 7, 2018 and therefore remedies outlined in our letter to you dated April 16, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K8T1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00749

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245261**

2.STATE VENDOR OR MEDICAID NO.
(L2) **484243000**

3. NAME AND ADDRESS OF FACILITY
(L3) **WOOD DALE HOME INC**
(L4) **600 SUNRISE BOULEVARD**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/29/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Koch, HFE NE-II 05/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/04/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2018

Ms. Judith Sandmann, Administrator
Wood Dale Home Inc
600 Sunrise Boulevard
Redwood Falls, MN 56283

RE: Project Number S5261028

Dear Ms. Sandmann:

On March 29, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 8, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 8, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 29, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/26/18 through 3/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/26/18, through 3/29/18,, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		5/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified morning and rising routines were implemented for 3 of 4 residents (R4, R29 and R1) who were dependent upon staff for transferring and activities of daily living (ADL)'s.	F 550	F000 This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency exists or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 Findings include: R4's annual Minimum Data Set (MDS) dated 1/3/18, indicated R4 was severely cognitively impaired. The MDS indicated R4 was totally dependent on staff for completion of all activities of daily living, mobility and locomotion. During observation on 3/28/18, at 7:01 a.m., R4 was lying in bed, asleep, the call light was clipped on the top of her blanket. R4 was wearing a blue-colored blouse, which could be seen where the blanket did not fully cover her. At 8:43 a.m., nursing assistant (NA)-C entered the room, announcing she would be helping R4 get up for breakfast, and approached R4, who was now awake. During the provision of cares, NA-C removed the blanket that covered R4, who was already dressed in the blue blouse, an incontinence brief, and had dark blue-colored pants on that were pulled down her legs. R4 was also wearing socks. After checking R4 for incontinence, NA-C provided peri care, then pulled up R4's pants. With the assistance of NA-D and a mechanical lift, R4 was transferred into the wheel chair. A few minutes later, NA-C pushed R4 from her room into the dining room for breakfast. When interviewed on 3/28/18 at 9:00 a.m., NA-C stated R4 was almost fully dressed this morning. They only had to change her incontinence product and pull her pants up. NA-C stated R4 required total assistance for all activities of daily living and, typically, the overnight shift staff washed R4 during their final round, got her dressed, and kept her in bed so she can sleep. The last round was completed "five-thirty, six	F 550	that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. F Tag 550 Comprehensive Care Plans (Qualified Persons) It is the policy of Wood Dale Home that "the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility…"A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality….. "The facility must provide equal access to quality care regardless of diagnosis, severity of condition or payment source…."The resident has the right to exercise his or her rights as a resident of the facility….."The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination or reprisal from the facility….."The resident has the right to be free of interference, coercion, discrimination or reprisal from the facility in exercising his or her rights and to be supported by the facility……" What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Direct care staff will provide morning cares for R4, R29, and R1 only after these residents initiate the desire to rise by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 o'clock." NA-C stated R4 was toileted and repositioned every two hours, and on the last rounds during the night shift, R4 also got medication. NA-C stated when that happens, "they do it all". They get R4 changed and dressed at the same time and remained in bed dressed until we get her up, which was around eight forty-five, when R4 had breakfast. When interviewed on 3/28/18 at 9:35 a.m., nursing assistant (NA)-F stated she worked on the overnight shift, and during last rounds, they got R4 up, cleaned, dressed, and then put back to bed, between 5 and 6:30 a.m. this morning. NA-F stated R4 was usually sleepy when then helped her on the last rounds, and after R4 is repositioned, cleaned and dressed, she stays in bed and continues to sleep. NA-F also stated they assisted R29 and R1 during rounds last night. NA-F stated routinely, between five and six in the morning on the last rounds, R4, R1 and R29, "the hoyer lifts (mechanical lift for transferring)", which are the residents, "who required two assist," would be dressed and washed. NA-F stated they announced in report to the oncoming, morning shift who was already dressed and washed for the day. NA-F stated when she worked morning shift, those three (R4, R1 and R29) would be "ready to go," and then we only had to check them for wetness. NA-F stated it "helped out" the morning shift staff. When interviewed on 3/28/18 at 9:50 a.m., NA-A stated R1, R4 and R29 all required the use of a hoyer lift, and needed two people to assist. These resident were assisted at night "to help the day staff." NA-A stated if those residents were dressed on the night shift, they could be "freshened up, changed" and then we get them	F 550	request or other predetermined indicators as stated on care plan. On completion of morning cares residents will continue to breakfast or other gathering area. Social Service designee will discuss with resident representatives/POA at Care Conference individual preferences related to AM rising rituals and update care plan as necessary. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice care plans will be reviewed, revised and updated for rising rituals and indicators that tell staff when resident is ready to start their day. Social Service designee will discuss upon admission and at Care Conference with resident and family what the resident's AM rising preferences/rituals are and update Care Plan as necessary. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Dignity policy and Providing AM & HS Care in a dignified resident centered manner policy will be reviewed and updated as necessary. Education related to dignity and AM & HS cares will be provided to staff prior to May 7, 2018. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 up. NA-A stated she was no sure how long this had been done, but having those residents done "makes a difference" for the day staff. When interviewed on 3/28/18 at 2:48 p.m. NA-B stated R4, R1 and R29 were "usually washed up" on the last round on the night shift, and then in the morning we only had to "check and change." NA-B stated it was not "mandatory" that the night shift staff got those residents up, nor was it expected, but stated "It's a helpful thing the overnights do." R29's quarterly MDS assessment, dated 3/15/18, indicated she was severely, cognitively impaired. The MDS indicated R29 was totally dependent upon staff for toileting, transferring, locomotion, and personal hygiene, and also that R29 required extensive assistance for dressing and eating. During observation on 3/29/18 at 8:08 a.m., R29 was observed in bed, partially covered by a blanket, and asleep. R29's brown-colored print, long-sleeved blouse could be seen, as well as her dark pants, which were partially covered by the blanket. Later, at 8:23 a.m., R29 was observed in the dining room, dressed in the dark pants, and brown, long-sleeved blouse. These were the same clothes she was wearing while in bed. When interviewed on 3/29/18 at 8:29 a.m., nursing assistant (NA)-D stated R29 was already dressed this morning, and that "overnights" normally gets R29 dressed on their last rounds at night. NA-D stated they normally get a couple of other people up, actually its all the resident who sit together to eat, R4, R1 and R29. NA-D stated	F 550	ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Charge Nurse will perform audits of AM and HS cares to ensure resident preference is respected and Care Plan is followed on 5 residents weekly for 2 months. Revision of Care plans will be made as needed. Audit results will be reported to the QAA committee for review and further recommendations at the May, 2018 quarterly meeting. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

is the night shift got a few people up, it would make the morning routine a little better, so everybody could be at breakfast on time. "It would help the day shift." NA-D stated.

When interviewed on 3/29/18 at 1:53 p.m., licensed practical nurse (LPN)-A stated that sometimes the residents who require the assist of two staff were "helped" during the last rounds. LPN-A stated for example one resident needed to be catheterized around 5:00 a.m., and since he also needed to be turned and repositioned, staff would also just wash him up and get him ready, but not out of bed. LPN-A insisted there was "no list or quota" of residents who had to be washed and dressed by the night staff, but stated she felt when a resident was up, it was "by resident choice."

R1's significant change MDS dated 12/28/17, indicated R1 had severe cognitive impairment and had physically resistive behavior towards others on one to three occasions during the assessment period. R1's medical diagnoses included Alzheimer's disease and a long-term degenerative disorder of the central nervous system which affected the motor system (movement and mobility). The MDS indicated R1 received extensive to total assistance with activities of daily living (ADL's), including dressing, grooming, bathing and mobility.

R1's care plan last revised on 5/21/17, identified an ADL self-care performance deficit related to Alzheimer's, Confusion, disease which affects mobility and impaired balance. The care plan directed staff to provide a consistent routine with care givers to help decrease R1's confusion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

During observation on 3/29/18, at 8:05 a.m. R1 was lying on his bottom sheet, with a fleece throw on the floor at the resident's bedside. R1 was dressed with his shirt and socks in place and R1's pants were noted to be pulled up to thighs, with the incontinence brief visible.

At 8:25 a.m. nursing assistant (NA)-C entered R1's room to assist R1 up for breakfast. R1 had been continuously observed from 8:05 a.m until 8:25 a.m.. R1 was noted to be resting on bed, with eyes closed, and easy respirations. R1's fleece throw was on the floor at R1's bedside. NA-C stated R1 often threw his blanket on the floor. Upon NA-C's verbal interaction in greeting resident, R1 mumbled incoherently but did not open eyes immediately. NA-C stated the overnight staff had provided assistance to R1 by assisting to wash face, hands, and perform pericare, assist with incontinence cares, and completed dressing typically between 5:00 a.m. and 6:00 a.m during their last rounds to assist the day shift with their work load. NA-C provided prompts to resident and then checked incontinence brief and assisted to pull up slacks. R1 was observed to open eyes and track NA-C while cares were provided. At 8:32 a.m., NA-D entered to complete the transfer via the Hoyer lift for R1. NA-D stated there are generally three residents assisted up by the night shift prior to 6: 00 a.m.

During interview on 3/29/18, at 2:33 p.m. the social service designee (SSD) stated she was aware some residents were assisted with cares on the final 6:00 a.m. rounds, adding this was done to assist the day staff. SSD stated if the residents didn't mind this wouldn't be a problem but stated R1 and the others identified were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7 unable to communicate their wishes. The SSD stated she was unsure if the families were consulted regarding early morning assistance for the residents. During interview on 3/29/18, at 4:00 p.m. the director of nursing stated she was aware of the night shift providing morning cares to some residents during the last rounds between 5:00 and 6:00 a.m., adding the residents would remain in bed until a later time, until gotten up for breakfast. The DON stated she was unaware of a concern with this practice. A facility policy, Quality of Life - Dignity, revised August 2009, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy also indicated staff shall treat cognitively impaired residents with dignity and sensitivity. The policy indicated "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self worth.	F 550		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F 577		5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 8 and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent and last 3 years of State agency survey results were easily accessible to residents and the public for review. This had potential to affect all 28 residents (R10, R16, R19, R23, R27, R80 and R230), visitors (FM-A) and staff, who wished to review this information. Findings include: During observation 3/27/18, at 2:30 p.m. the bulletin board across from the nurses station included a sign indicating survey results were found in the family room by the entrance of the facility. At 2:35 p.m. the survey results were not found in the family room. During interview on 3/27/18, at 2:45 p.m. the administrator indicated the survey results were in the room adjacent to the family room. The room adjacent to the family room was labeled "conference room". The administrator stated the	F 577	F Tag 577 Right to Survey Results/Advocate Agency Info It is the policy of Wood Dale Home that the the resident has the right to (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect&.The facility must (i)Post in a place readily accessible to residents and family members and legal representatives of resident&..(ii) Have reports with respect any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding year, &.(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public&.. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The survey results are now posted in a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 9 survey results were kept in the magazine rack on the wall inside the conference room. If residents or the public would want to review the previous 3 years, they could request them. The administrator kept the previous years surveys in her office. There was no signage to indicate who to make a request to in order to review those survey results. The administrator immediacy showed the survey results located in the conference room. The forms included documents that were not official Centers for Medicare and Medicaid (CMS) form 2567. The facility had typed a summation on a word document and printed it for residents and the public. This did not include all federal CMS deficiencies cited, nor the scope or severity. It also did not include state issued deficiencies. The administrator stated she altered the CMS- 2567 so those who needed bigger print could read it. On 3/26/18, at 3:35 p.m. family member (FM)-A stated there was a sign posted by the nurses station on the wall that mentioned survey results. He was unsure where the survey results were physically located as he had not seen them in the family room. On 3/27/18, at 3:15 p.m. during resident group meeting, R10, R16, R19, R23, R27, R80 and R230 identified they were not aware of the survey results location.	F 577	new location that is centralized, wheelchair accessible, and easily viewable. This notebook of information including CMS Form 2567 is available in the resident family area in the lobby of the main entrance and also in the resident hallway near the main entrance. The notebook of survey information also includes a notice indicating the Health Department surveys from the previous three years are available from the Office. At Resident Council meeting to be held on April 30, it will be discussed with residents and residents will be educated on the new survey results location. The new location for the most recent survey results will be reviewed at future resident council meetings as well. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Same as above - Notification and location of posted survey results will be added to the admission packets of new residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy for examination of survey results will be reviewed by interdisciplinary team in April. Staff members will be trained on the policy updates by May 7, 2018. How the facility plans to monitor its performance to make sure that solutions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 10	F 577	are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Social Service designee or Administrator will audit resident council meetings minutes once per month X3 months to ensure the location of survey results is discussed with residents and as needed. Social Service designee or Administrator will audit survey results posting to ensure that it is centralized, wheelchair accessible and easily viewable for 5 days per week X2 weeks and weekly after that for one month. Who is responsible for this plan of correction? The Administrator or Social Service designee will be responsible for compliance. Date of Correction: 5/7/18	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-	F 660		5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 11	F 660		

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 12 SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide assistance with discharge planning for 1 of 1 residents (R16) reviewed for discharge planning. Findings include: R16's Admission Record printed 3/29/18, indicated R16 admitted to the facility on 6/6/13, with a non-pressure chronic ulcer of the foot unspecified, chronic kidney disease, and diabetes. R16's admission record did not identify a case manager at the county level.	F 660	F Tag 660 Discharge Planning Process It is the policy of Wood Dale Home to develop and implement an effective discharge planning process that focuses on the resident□s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions&&. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 13 R16's annual minimum data set (MDS) dated 2/9/18, indicated R16 had intact cognition, but displayed some inattentiveness. The MDS indicated R16 was independent with activities of daily living (ADL's), requiring only supervision with dressing and grooming. R16's medical diagnoses included hypertension, diabetes mellitus, and depression. The MDS indicated R16 had participated in goal setting and expressed a desire to return to the community however, no active discharge planning had been completed and no referrals had been made. During interview on 3/26/18, at 5:43 p.m. R16 stated his desire to move out of the facility and return to the community where he could be involved with friends and participate in activities of interest to him. R16 stated he had expressed his wishes to the facility but was unaware of any specific plans nor was he aware of having a case manager assigned to him outside of the facility. R16's care plan last revised on 2/16/18, indicated R16 wished to return to his home when his condition improved. The care plan further identified the following interventions: to establish a pre-discharge plan with R16 and family member and evaluate quarterly, encourage R16 to express his feelings and concerns with staff, and social services would prepare and provide R16 and family members with contact information for all community referrals. R16's care plan further identified on 3/16/17, that R16 received an antidepressant related to depression from feeling of being "stuck here." The care plan interventions directed the staff to administer medications as ordered, while R16 was monitored for adverse effects such as mood changes, social isolation, and change in mobility.	F 660	Social Service designee will schedule a discharge planning meeting with RN Case Manager, R16 and his family representative to discuss a plan for discharge and identify and document R16□s discharge needs. Social Service designee will also request referral for county case worker to help with discharge planning. Following discharge planning discussion, referrals will be made as necessary to facilitate R16□s discharge back to the community if that is what is deemed to be appropriate for this resident. All steps including referral information and follow up will be documented in R16□s chart. All relevant information will be incorporated into the discharge plan on an ongoing basis to help facilitate its implementation and avoid unnecessary delays. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may have been affected, Social Services will assess discharge wishes of each resident and/or family representative upon admission and continue to assess during assessment review dates, then document in chart and update care plan as needed. Once discharge goals have been established, Social Services designee along with nursing will work with resident and family to identify specific resident needs after discharge and incorporate these needs into the discharge plan to facilitate its implementation and avoid unnecessary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 14 During interview on 3/26/18, at 7:06 p.m. licensed practical nurse (LPN)-A stated R16 was scheduled for a neuropsychiatry consultation on 3/17/18, for assessment of R16's capability to live in a more independent living situation. LPN-A stated approximately a year ago, discharge planning was initiated for R16 and he had been working at performing independent glucose monitoring in preparation for a move to a more independent setting. LPN-A stated R16 had expressed his wish to discharge to the community. On 3/29/18, at 11:16 a.m. the director of nursing (DON) stated the facility had been trying to get services in place for discharge planning "for the last couple of years." The DON stated R16 is his own person and they have worked to assist with placement in a more appropriate environment for him based on his abilities and psychosocial needs. The DON stated the facility had worked with R16 and his family member on this process. The DON stated R16 did have a county case manager, however, was unaware of who it was. The DON stated the staff member previously in the role of social services designee was not available for interview and the DON was unable to find documentation to reflect what had been done with R16 in relation to discharge planning. A call was placed to Southwest Health and Human Services (Redwood County Social Services) in follow up on 3/29/18, at 5:30 p.m. with a message left for return call and no follow up was received. A call was placed in follow up and a message was left with the intake staff on 4/2/18 at 9:00 a.m. requesting a follow up call from R16's County Case Worker. A return phone	F 660	delays. Discharge planning will be an ongoing process from the time of admission and will continue throughout stay. Discharge goals will also be reviewed and discussed with resident and family representative during Care Conference. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy for Discharge Planning will be presented at QA for our medical director and other QA team members for review and input. Training will be provided regarding Discharge Planning with licensed staff bi-annually and as needed during licensed staff meetings. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Interdisciplinary team will review residents discharge plan during resident□s assessment review dates to ensure that discharge planning is ongoing and to provide guidance as needed. Discharge planning goals will be identified in each resident□s care plan, discussed and documented at each resident care conference and in each care conference summary. Social Service will audit each resident care plan for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 15 call was not received. During interview on 3/29/18, at 4:31 p.m. family member (FM)-B stated they had met with a county case manager approximately two years ago to look at alternate living arrangements but no plans were developed. FM-B stated they were aware of R16's wish to live in a more independent setting, and had been working with the facility, but there were no plans in place. A policy was requested for the discharge coordination and planning process but was not provided.	F 660	inclusion of discharge planning prior to May 7, 2018. Thereafter Social service will use the quarterly MDS/Care Conference schedule of residents to audit the care plans for the inclusion of discharge planning for three months. Results of such audits will be shared at next QAA meeting in May and again in August for further recommendations. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 16 representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an appropriate discharge summary had been completed for 1 of 1 residents (R31) who was discharged to home. Findings include: R31 was admitted on 10/17/17, with a diagnosis of displaced sub-trochanteric fracture of the right femur (a fracture of the right hip), a history of repeated falls, syncope (fainting/a temporary loss of consciousness) and collapse, and muscle weakness identified on the admission face sheet. R31's admission minimum data set (MDS) dated 10 /24/17, indicated R31 had intact cognition and received extensive assist of two staff to complete activities of daily living (ADL's) which included dressing, grooming, and bathing. R31's discharge MDS dated 12/28/17, indicated moderate cognitive impairment and improvement	F 661	F Tag 661 Discharge Summary It is the policy of Wood Dale Home to complete a discharge summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident□s stay&. (ii) a final summary of the resident□s status&..(iii) Reconciliation of all pre-discharge medications with the resident□s post-discharge medications (both prescribed and over-the-counter. (iv) A post-discharge plan of care &.. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R31 has discharged to home and is no longer a resident at Wood Dale Home How will you identify other residents having the potential to be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 17 in ADL's to independent status. R31's PT Progress and Discharge Summary dated 12/27/17, identified R31 had therapy in the facility to improve mobility, maximize safety and independence with mobility to allow return to previous living situation with outpatient therapy. R31's OT Progress and Discharge Summary dated 12/27/18, indicated R31 received therapy for pain and edema management. Additionally, OT addressed R31's safety and cognitive skills development with management tasks for personal skills, medication management, and safety in home and community settings. R31's OT discharge plan included plans for home exercise therapy and home health services for supervision with bathing and med set up. R31's progress notes indicated the following: 12/27/17, at 5:01 p.m. indicated skilled services of OT/PT had been completed. The documentation indicated the home health agency met with her on that date and reviewed available services, however, did not address which home health agency or the outcome of the meeting. 12/27/17, indicated orders were received from the doctor to discharge home with outpatient services, however, did not specifically identify what services were ordered. 12/28/17, at 1:59 p.m. indicated R31 was discharged from the facility at 12:00 p.m. escorted by son with personal belongings. The documentation identified R31 was provided with medication instructions and medications were sent with. The documentation did include a	F 661	same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice; Charge nurse or Case Manager will be responsible for writing a discharge summary on the day of discharge that includes but is not limited to A recapitulation of the resident□s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. A final summary of the resident□s status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident□s representative. Reconciliation of all pre-discharge medications with the resident□s post discharge medications (both prescribed and over the counter. A post discharge plan of care that is developed with the participation of the resident and, with the resident representatives consent at a discharge care conference, which will assist the resident to adjust to his or her new living environment. Summary will also indicate where the individual plans to reside. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Revised policy will be reviewed by QA and changes made if needed. Licensed staff will receive training on new discharge summary policy by 5/7/18. Policy will be reviewed and updated as needed annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 18 summary of R31's course of stay at the facility,including; treatments provided, or reconciliation of pre-discharge and post-discharge medications. R31's undated Discharge Instructions for Care indicated R31 was being discharged to home. The document lacked entries for the following sections: follow up physician care, treatments, mediations, nutritional status, and current physical status(outside of independence with mobility with four wheeled walker). The discharge instructions lacked areas to address cognition, mood or behavior concerns, psychosocial concerns, dentition, or activity concerns. The instructions did not list the primary physician or any contact information for the provider. During interview on 3/29/18, at 3:04 p.m. the director of nursing (DON) stated a discharge summary was to be completed at the time of discharge which included cognitive ability, mobility, orders and recommendations from therapies, any discharge teaching done, and medications. The DON stated the medication administration record was provided to resident/family to inform them of current medications ordered. The DON stated the mode of transportation and ability was also to be documented. The facility Discharge/Transfer of the Resident policy revised 10/12, and indicated upon discharge a summary was completed in conjunction with a post discharge plan of care form. The policy did not include the requirement of review of the resident's stay (recapitulation), and reconciliation of pre-discharge and	F 661	How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Audits of completion of discharge summaries will be performed monthly for three months by Social Service designee . Results of audits will be presented to the QAA Committee in May and August for further recommendations. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 19 post-discharge medications.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 20 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide supervision and cues during meals for 1 of 1 residents (R8) whom required staff direction for eating. Findings include: R8's annual minimum data set (MDS) assessment completed on 1/18/18, indicated R8 had moderate cognitive impairment and required supervision with eating after set up of meal. R8's medical diagnoses included gastric esophageal reflux disease (a condition that develops when gastric acid from the stomach travels up into the esophagus). R8's care plan dated 3/12/ 18 identified R8 was independent with meals after set up and at risk for dehydration. R8's interventions indicated R8 staff were to provide safety precautions and offer safety cues while R8 ate and drank to prevent aspiration. R8 was to receive thickened liquid. The care plan did not identify interventions to be implemented related to speech therapy recommendations with specific prompts, cues, and supervision required while eating and did not reflect R8's current pureed diet. During an observation of the evening meal on 3/26/18, at 5:40 p.m. R8 had a dining cue card placed in front of him. The dietary card directed staff to assist R8 as follows: supervision to cue for use of strategies due to aspiration risk. R8 was to take small bites and small sips, sit upright at a 90 degree angle at the table during the meal	F 676	F Tag 676 Activities of Daily Living It is the policy of Wood Dale Home to provide ADL□s Based on the comprehensive assessment and consistent with the resident□s needs and choices,&.(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including: (b) Activities of daily living&.. (1) Hygiene □ bathing, dressing, grooming and oral care. (2) Mobility-transfer and ambulation, including walking (3) Elimination □ toileting (4) Dining-eating, including meals and snacks (5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R8□s Care plan has been updated to reflect the assistance recommended by speech therapy. Staff sits next to R8 through-out meal time to assist with cues and prompts as outlined by speech therapy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 21 and to remain upright at a 90 degree angle for 20-30 minutes after meal. R8 was not to not use a straw and was to avoid dry or crumbly foods, identified as nuts, lettuce, rice, and mixed textures. R8 was to alternate solids and liquids, taking two bites of food and then a sip of liquid and was to be instructed/prompted to swallow what's in mouth before another bite/sip was taken. This information was not outlined on the care plan. During the meal, R8 seated with another resident R11 and their guest FM-C. Once the tray was delivered to R8, there was no further verbal prompts or cues provided to resident. Although staff were observed at other tables in the dinning room, R8 had no further prompts and cues provided. R8 was observed to eat the meal without experiencing coughing spells or evidence of choking. On 3/27/18, at 12:38 p.m. R8 was observed in the dining room eating his noon meal. The staff instruction card was placed by R8 with his meal, however, there was no staff assistance observed at R8's table throughout the meal to provide verbal prompts or cues. R8 was observed to eat his meal without experiencing coughing spells or evidence of choking. On 3/28/18, at 8:26 a.m. R8 was observed eating breakfast of pureed eggs, cooked cereal, fruit and yogurt. The written cue card was placed at the table . During the meal service, dietary staff was observed to interact with R8 in passing. Nursing assistant (NA)-E was assisting a table next to R8, however, her back was to him. R8 was not offered prompts or cues to take small bites and swallow. Although he consumed his pureed diet,	F 676	by this practice speech therapy will provide nursing with a definition of terms used to describe level of assistance needed. When Speech Therapy determines a resident is in need of assistance with eating, the Speech Therapist will update Charge nurse, dietary, and Dietary Manager regarding any changes related to assistance and/or cues needed during meal time, Dietary Manager will update Care Plan, document change in progress notes, and write a communication note on the 24- hour shift report. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The revised policy for Activities of Daily Living will be presented at QA for our medical director and other QA team member to review in May and August for necessary changes. Staff will be trained on Activities of Daily Living policy changes by 5/7/18. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Activities of Daily Living policy will be reviewed annually and revised as needed. RN-CM will perform weekly audits x 4 weeks to ensure correction is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 22 R8 was not alternating with fluids, nor did he drink fluids provided. At 8:31 a.m. R8 had pushed his plate away from him. R8's thickened water and juice were noted to be outside of R8's reach. At 8:35 a.m., R8 was approached by dietary staff to ask if he was done with his breakfast and R8 stated that he did not wish to eat any more. At 8:38 a.m., R8 was assisted from the dining room after consuming the majority of his foods, however, had only a few sips of thickened liquids. R8 was not offered encouragement or prompts to consume any additional liquids. R8 did not attempt to reach fluids, or express interest for beverages. On 3/28/18, at 2:20 p.m. the speech language pathologist (SLP) stated R8 had started therapy on 3/18/18, related to episodes of choking/coughing at meals. SLP stated in light of R8 not using his partials a dietary downgrade was implemented to mechanical soft ground meat and nectar thick liquids. This was not successful for R8 as they observed more effortful swallows, and a pureed diet was recommended. SLP stated a swallow study had been scheduled but was unable to be completed until 4/16/18, and interventions were recommended in the interim. The SLP stated with a pureed diet, R8 was able to swallow more easily and his voice was clearer. The SLP stated her expectations for assistance with R8 was for staff to sit with him at all meals, and offer verbal cues in addition to non-verbal visual cues (placing glass near him). The SLP stated if staff were not sitting with him, R8 may not take the second sips, adding there should be one person at his table to provide verbal prompts and cues. The SLP stated if R8 was not cued, he may not take liquids at a 100% which places him	F 676	and sustained. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 23	F 676		

at risk for poor hydration which could lead to urinary retention and dehydration. The SLP stated when making recommendations, a copy of the recommendations was provided to the charge nurse who was to pass it on in report and update the care plan. A copy of the recommendations was also provided to the dietary manager who will then laminate and instruct staff to place out with meals.

During interview on 3/28/18, at 2:40 p.m. NA-E stated R8 required supervision at meals and stated R8's diet had been changed to pureed with thickened liquids. NA-E stated she is often in the dining room alone so was "supervising everyone." NA-E stated R8 had instructions to to take two bites, followed by a drink. NA-E stated at times R8 required cues to make sure he was taking his drinks.

On 3/28/18, at 2:51 p.m. licensed practical nurse (LPN)-A stated her understanding of supervision for residents was someone needed to be present in the dining room, but did not mean someone needed to be seated with him. LPN-A stated this type of supervision would be considered a one to one or assist to feed, adding there would need to be orders for one to one for this level of supervision. LPN-A stated the care plan should be updated by the nurse receiving the orders or by the Case Manager.

On 3/28/18, at 3:09 p.m. registered nurse (RN)-A stated R8 was in "bird's eye view" by staff who who were seated diagonally across the room assisting other residents. RN-A stated a person would need to be sitting next to R8 in order to provide the assistance as outlined on the dietary cared. RN-A stated there was a difference

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 24 between supervision and one to one assistance and indicated supervision was staff present in the dining room, but the assistance described fit the criteria for one to one assistance. RN-A stated the care plan was updated by the dietary manager and revised as needed by the dietitian during their monthly review. The facility Specialized Rehabilitative Services policy revised 12/09, indicated once a resident met their care plan goals a licensed professional can initiate a maintenance program to assure the resident maintains his functional and physical status. The policy did not identify the specific process as to when the care plan was updated while therapy was working in conjunction with nursing staff.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and care plan activity needs for 3 of 3 residents (R4, R25 and R1) who were dependent on staff for activity involvement.	F 679	F Tag 679 It is the policy of Wood Dale Home to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 25 Findings include: R4's annual Minimum Data Set (MDS) dated 1/3/18, indicated R4 was severely cognitively impaired and totally dependent on staff for mobility and locomotion. The MDS "Preferences for Customary Routines and Activities" section indicated it was "very important" for R4 to do favorite activities and "very important" for R4 to listen to music and "somewhat" important" for R4 to do things with small groups. The MDS also indicated R4 was dependent upon staff for mobility to and from activities. R4's annual care area assessment (CAA) for activities, dated 1/3/18, indicated with "checks" in pre-populated responses that: R4's pre-admission preference were "group" activities; and identified issues that resulted in reduced activity participation which included: mobility problems, unstable health problems, use of psycho-active medications, cognitive deficits; and chronic health conditions. The CAA provided no further information related to R4's activity preferences such as R4's lifetime interests, hobbies, customary routines; or specific information about R4 likes, such as music, and what kind of, when and where R4 may have music available; or other pertinent information such as need for a limited participation time, or other supports during activities. R4's care plan, with a goal target date of 4/8/18, did not specifically address activities. In the focus area "[R4] has delirium and/or hallucinations" the staff were directed to "Engage [R4] in simple activities that avoid overly demanding tasks. The Care plan lacked any additional focus, goals, or staff interventions related to R4's activities.	F 679	program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident R4 will be invited and encouraged to listen to music, do things in small groups and do favorite activities eg. Listening to country music in resident room or interacting with others in resident day room, group music entertainment. Assistance with mobility will be provided by staff. Activity Director will complete a comprehensive assessment of R4□s activity needs, care plan interventions to meet those needs. Will be offered one to one music at various times Resident R25 will be interviewed, reassessed and care planned for individual and small group activity preferences, will be invited to attend activities with music, will continue to be invited to other group activities so that he can continue to attend those that he chooses to attend. Will be offered one to one sensory simulation at various times. Resident R1 will be reassessed with prior activity preferences and current activity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 26 A quarterly activity assessment for R4, dated 4/20/17, indicated in the "Attendance and Participation Summary": [R4 passively attends activities; [R4] enjoys music and one-to-one interactions. In the "Activity Plan Review" section, three pre-populated responses were noted: Resident's activity-related focuses remain appropriate as per current plan of care; goals were met; and interventions/approaches have been effective in reaching goals. Another quarterly assessment was dated 7/12/17. The narrative and pre-populated responses on this form were identical to the assessment dated 4/20/17. R4's record lacked a quarterly assessment for October 2017. During observation on 3/26/18, at 2:38 p.m. R4 was in her room lying in her bed and awake. The drapes were pulled and the room light was off. To the left of R4 on a night stand was a radio/CD player, but it was not playing. R4 remained in her room, in bed, with drapes pulled when staff repositioned her just before 4:00 p.m. R4 remained that was until 5:48 p.m., when staff transferred her into the wheel chair and brought to the dining room for the evening meal. R4's room was quiet the whole time. When interviewed on 3/26/18, at 6:57 p.m., family member (FM)-A stated when she comes to visit if R4 is not in her room sleeping, FM-A would find R4 in the day room where she could "interact with other staff and residents" and be "out" and get stimulation from the TV. FM-A stated R4 "really enjoys music, especially country music," and would sing or hum along to music when she heard it. FM-A stated R4 also enjoyed watching the music entertainment at the facility. FM-A stated R4 had a CD player in her room, with a	F 679	interests noted, care planned for individual and small group activities, will be invited to small groups eg. physical exercise group, coffee time, and invited to large group music programs. Care Plan does reflect R1 tendency refusal of activities and staff will be training on responsibility for documentation. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice, the Activity Director will review and reassess as needed the individual preferences of our residents, care plan for participation in appropriate activities eg. Small and large group as well as individual activities. The preferences for participation of our residents will be communicated to activity staff and nursing staff for follow through of provision of activity preferences of the individual residents. The process for activity staff and nursing staff to follow will be reviewed and revised so that the activity preferences and care planned needs of the residents are provided. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policies of Activity Assessment, Activities Care Plan, Activity Programs, Group Programs and Activities Calendar, Individual Activities and Room Visit Program will be reviewed and revised	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 27 supply music, and thought staff played CDs when R4 was in bed resting. FM-A stated R4 was dependent upon staff for getting her out of her room and taking her down to the day room or the dining room for the group music programs. During observation on 3/27/18, at 9:12 a.m. R4 had just been assisted to eat breakfast. Staff propelled her from the dining room and into the day room where a western show was playing on the television. Two other unidentified residents were in the room, one asleep in a wheel chair, and another seated in a recliner eating puffed corn. R4 was asleep in her chair, in front of the television. At 2:51 p.m., R4 was lying in bed in her room. The bedroom drapes were pulled, R4 was asleep; and the room was quiet. During observation on 3/28/18 at 9:39 a.m. following breakfast, nursing assistant (NA)-A removed R4 from the dining room and mentioned to R4 the "Price Is Right" was going to be on television. NA-A moved R4 from the dining room to a spot in front of the television in the day room. At 10:05 a.m., R4 was in her wheel chair, slightly reclined, a neck pillow around her shoulders, with her eyes open. At 10:12 a.m. R4 was asleep in front of the television. When interviewed on 3/28/18 at 9:54 a.m., nursing assistant (NA)-A stated R4 liked music and also liked to lay down and sleep. NA-A stated R4 had music in her room which was usually on at night, but not during the day. NA-A was not aware of other specific activity engagement for R4. When interviewed on 3/28/18 at 1:14 p.m. the activity assistant (AA) stated R4 liked "classical"	F 679	as needed. Activities staff will be retrained on the process to be followed to assure the activity preferences and care planned needs of the residents are provided. Guidance will be developed for Activities staff to follow and assist in revising based on communication from residents as to their preferences and observed involvement in various activities. Nursing staff will be retrained on the process and expectation of staff for meeting identified activity needs for individual residents. Initial retraining will be prior to May 7, 2018 and further staff training will be scheduled within the planned annual staff training. The IDT Team will assist in identifying unmet needs of individual residents for more involvement and offering of activities to our residents who need assistance with mobility, communication and participation in large group, small group and individual activities. The Activity Director is a participant in the IDT Team. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Activity assessments, CAA and care plan audits will be completed for our residents initially by Activity Director and IDT FSM	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 28 music, was aware there was a CD player in R4's room, but was not sure when or how often staff played music. AA-stated R4 enjoyed live music presented at the facility. The AA was not familiar with R4's interests or specific care-planned activities, but stated, R4 had "one-to-ones" a few times during the week, and also stated he tried to engage R4 in small groups. AA did not think R4 had any "independent" activities, because she was dependent upon staff for her activity and stimulation. When interviewed on 3/29/18, at 8:32 a.m. NA-D stated R4 liked to sing along with "Elvis" and the "Coal miner's Daughter"; NA-D stated R4 likes music, had a (CD) player in her room, but was not sure when or how often music was played. NA-D also stated R4 used paint, and wondered, would R4 still do that? NA-D also stated R4 enjoyed her nails done, and R4's activity interests would be spelled out "in her care plan." When interviewed on 3/29/18, at 9:50 a.m., the activities director (AD) reviewed R4's record and acknowledged R4's most current activity assessment was dated July 12th, and stated "I'm overdue" and that R4 needed a quarterly activity assessment for October. The AD stated R4 enjoyed music, listening to both live and CDs, and stated staff did one to one visits with her. The AD stated in the past months R4 had been resting more, and staff were to invite and encourage R4 to participate in activities only if she was awake. The AD reviewed R4's participation documentation, and stated there was documentation that indicated R4 did independent activities, but was unable to state what R4 did independently, because she relied on staff to initiate activity stimulation. After reviewing R4's	F 679	Office Assistant. Further audits will be conducted quarterly utilizing the MDS schedule with results reported to the QA/QI Committee for review and further recommendations. Further system revision and staff education will be provided if indicated by audits. Resident attendance at activities will be monitored monthly by Activity Director with revision to process of encouraging and assisting residents to activities as individually preferred. Results of audits will be shared at next QAA meeting in May and again in August for further recommendations. Who is responsible for this plan of correction? Activity Director is responsible will be responsible for compliance. Date of Correction: May 7, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 29	F 679		

care plan, the AD stated there was no section that identified activities, or any details about when to play her music, especially since that was so important to her. The AD then stated R4's activity assessments and care plan "could be fleshed out more"

During observation on 3/29/18, at 2:12 p.m. R4 was seated in her wheel chair in the dining room, while a live, two-piece music group, including guitar, performed numerous country songs. During the performance R4 had her eyes open, was smiling, and at one point a man walked in front of R4 and her eyes and head moved from right to left as she tracked the man walk across the room. R4 was more animated and alert than during any other observation during the survey.

Although R4 was dependent upon staff, and was unable to physically participate in activities without staff assistance, the facility had not completed a comprehensive assessment of R4's activity needs or care plan intervention to meet those needs.

R25's annual MDS dated 12/14/17, indicated moderate cognitive impairment. The MDS identified it was "very important" to do his favorite activities and keep up with the news. R25's annual activity assessment dated 12/18/17, indicated R25 does not like to attend any activities, was a pilot instructor, speaks several languages, and also R25 enjoys television and will occasionally enjoy visiting with certain staff. The Care Area Assessment (CAA) for activities, dated 12/20/17, indicated a triggered area because [R25] does not participate in activities. The CAA indicated R25's preferences prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 30	F 679		

admission to be "group activities" and that current activity pursuits were "self-directed or done with others and /or planned by others. The CAA identified health issues that resulted in reduced activity participation, including indicators of depression, functional mobility problems, cognitive deficits and chronic health conditions, and also social-inappropriate behaviors. The assessment lacked any additional information such as R25's past interests, and specific details about how the resident prefers to participate, or if adaptations (such as increased print size or volume) were needed. The CAA identified only" [R25] gets one to one visits with staff, and he likes to independently watch TV."

R25's care plan for activities, revised 2/17/16, indicated he was independent for meeting emotional, intellectual, physical and social needs, and identified as a goal; R25 will maintain involvement in cognitive stimulation, social activities, as desired through review date. The care plan directed staff to converse with R25 while providing care and ensure the activities he attended were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed (such as large print, holders if resident lacks strength, task segmentation) and compatible with individual needs and abilities' and were age appropriate. R25's care plan also indicated 1 to 1 visits with activity staff as often as possible.

During observation on 3/26/18, at 3:27 p.m. R25 was pushed from the dining room and positioned at a table near the nursing station and day room areas. A staff member brought R25 a serving of ice cream to snack on, while he appeared to be people watching.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 31	F 679		

During observation on 3/27/18 at 4:12 p.m. R25 was seated in his wheel chair at a table, adjacent to the nursing station and day room. Two other residents are seated near R25 at the table, one of whom was looking at a newspaper. R25 briefly said something to a staff member who walked past him, then R25 smiled.

During observation on 3/28/18 at 8:53 a.m., R25 was moved from the dining room after breakfast into his room. After toileting, R25 was assisted into bed, where he remained until 11:37 a.m. Except for toileting upon R25's request at 9:22 a.m., R 25 remained in his room in bed, until staff summoned him prior to the noon meal, at 11:37 a.m.

When interviewed on 3/27/18 at 3:26 p.m. NA-G stated of late R25 had become more social. NA-G stated R25 liked to get out an talk with people and crack jokes, but wasn't aware of what other things he liked to do. NA-G stated it would be good fro R25 "to come out" visit more, and talk with the people.

During interview on 3/28/18 at 9:11 a.m., NA-F stated she was not sure what R25 liked to do. NA-F stated she heard R25 was a pilot when he was younger, and stated she that would be interesting to talk about. NA-F stated R25 more recently was getting go out of his room more, but didn't think he attended many activities.

When interviewed on 3/28/18, at 4:15 p.m. Activities assistant (AA) stated R25 "does not like to do activities," although invited, but added that in the past couple of months, R25 was coming out of his room more. The AA stated R25 did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 32	F 679		

attend church services, but did join the Thursday music performances "on occasion." The AA stated he has done one-to-one sessions with R25, but that he did mostly independent activity pursuits. The AA stated he was not all sure what R25's care plan included with regard to his activity interests.

When interviewed on 3/29/18 at 9:31 a.m., R25 stated he did like to participate in activities, "the ones I want," and added there was not much of real interest to do. R25 also stated he would go out of his room "to listen to music" but R25 offered nothing more regarding his interests.

A review of R25's activity participation log from 2/1/18 to 3/27/18 indicated he had 0x (times) " independent activity"; 21x "small group"; 25x "one-to-one"; 30x "coffee time"; 1x game; and 1x "entertainment". The documentation did not indicate specify or elaborate what the independent or small group activities were.

R25's quarterly activity assessment, dated 12/18/17 indicated R25 does not like to attend any activities, and that R25 was a pilot instructor, speaks several languages, is a high-ranking Mason's member, and enjoys television and will occasionally enjoy visiting with certain staff. The assessment indicated R25's activity goals were met and activity-related focuses remain appropriate/current as per current care plan. An activity assessment dated 3/9/18 indicated R25 was passively active and prefers to watch people and visit in a small group setting, that R25 sometimes like to watch television, enjoys people watching and sometimes likes to visit and share stories. The assessment indicated R25's activity goals were met, and activity-related focuses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 33	F 679		

remain appropriate/current as per current care plan.

During interview on 3/29/17, at 10:17 a.m., the Activities Director (AD) stated R25 was very smart, had a diverse background, was a pilot and spoke several languages, and also was "difficult to include for activities." The AD acknowledged she did not look for a root cause why R25 does not participate more in activities and stated R25's assessment was lacking in substance. The AD stated R25's care plan did not specify individual approaches for R25 and stated frankly it was probably "generic." The AD also stated although she felt R25 was getting activity stimulation, what he gets "could be improved."

When interviewed on 3/29/18 at 11:09 a.m., the facility administrator stated she acknowledged "there was an issue" with thoroughness of documentation for the activity assessments, as well and getting the information on the care plans, and executing the care plans. The administrator stated "we need to do more."

R1's significant change minimum data set (MDS) dated 12/28/17, indicated R1 had significant cognitive impairment and exhibited physically resistive behavior towards others. R1's medical diagnoses included Alzheimer's disease and long-term degenerative disorder of the central nervous system that mainly affected the motor system. The MDS indicated staff should assess residents preference for activities and attendance daily, however, no preferences were identified under staff assessment. R1's care area assessment (CAA) dated 1/2/18, identified activities as an an actual problem related to R1's inability to participate in activities due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 34	F 679		

developmental delays. The CAA indicated staff sat with R1 at times and indicated R1 enjoyed "shuffling papers." The CAA did not identify any activity preferences prior to admission nor did it identify current activity interests.

R1's Initial Activity Review dated 5/24/17, , indicated R1 was a passive participant in most activities and "enjoys watching the world around himself." the review did indicated R1 wished to participate in activities, including group activities, and required assistance to get to and from activities. A review of R1's Quarterly/Annual/Sig Change Activity Review of 3/22/18, identified the following: R1 was passively active in groups, and enjoyed snacks and eating.

R1's care plan initiated on 6/2/17, indicated dependence on staff to meet emotional, intellectual, and social needs. The care plan directed staff to ensure activities R1 attended were compatible with needs and abilities. The care plan directed staff to introduce R1 to others and facilitate interactions and to invite R1 to actives that promote physical activity such as exercise group. Staff were directed to be aware of R1's position when in groups, activities, and dining to promote proper communication with others.

On 3/26/18, at 2:35 p.m. R1 was observed in his room, lying in bed with the curtains drawn and lights off. R1 was noted to be awake and looking forward, fidgeting with a fleece blanket.

On 3/27/18, at 10:17 a.m. R1 was noted to be resting on his bed with eyes open.

On 3/28/18, at 10:14 a.m. staff were observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 35	F 679		

assisting R1 to lay down in bed to rest before lunch. The morning activity was set to start at 10:15 a.m.

On 3/28/18, at 1:26 p.m. R1 was observed in the day room area. The television was turned on to a talk show and the lights were off in the room. R1 was twisting and picking at the fleece blanket on his lap and was noted to quickly drift asleep. At 1:43 p.m. R1 assisted out of the day room and assisted to his room to lay down.

On 3/29/18, at 9:26 a.m. R1 was propelled by staff to the table near the nurses station which had newspapers present. He was seated in a semi-reclined position with his eyes closed. The staff did not verbally interact with resident while seating him at the table or attempt to engage him activity as indicated in the care plan.

On 3/29/18, at 2:17 p.m. a live music program was occurring in the dining room. R1 was not in attendance at the program. At 2:25 p.m. R1 was in his room, in bed, with his eyes open. R1 made eye contact when spoken to but response was not understood. The music program could be vaguely heard from R1's room.

During interview on 3/28/18, at 3:07 p.m. AA-A reviewed R1's recent activity attendance and identified many dates which indicated "active" and stated R1 was "active" in independent activity. AA-A stated R1 watched television in the dayroom. AA-A stated R1 participated in music every Thursday at 2:00 p.m., however, rarely participated in anything else.

A review of R1's activity attendance record from 11/28/17 to 3/28/17 indicated R1 had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 36 "active" on all documented dates with the following exceptions: one notation of refusal on 1/4/18, refused-in bed on 1/16/18 at 2:58 p.m. (however was also documented as "active" at 2:29 p.m.), and refused-in bed on 1/30/18, 2/6/18, 2/27/18, 3/20/18, and 3/27/18. The document did not provide a defintion as to perimeters for "active". R1 was noted as participating in entertainment only on 1/4/18 and 3/20/18. R1 was recorded as participating in coffee time on 1/18/18 only. R1 was denoted as receiving staff one to one visits on one occasion, 2/18/18. A facility policy, Activity Assessment, revised 11/9/12, indicated the resident's activity assessment was to be conducted by Activity Department personnel, in conjunction with other staff who will assess related factors such as functional level, cognition, and medical conditions that may affect activities participation. The resident's life long interests, spirituality, life roles, goal, strengths, needs and activity pursuit patterns and preferences will be included in the assessment. Further, the policy indicated the activity assessment was used to develop an individual activities care plan that would allow the resident to participate in activities of his/her choice and interest. A facility policy, Activity Program, revised 11/9/12, indicated activity programs were designed to meet the needs of each resident and were available on a daily basis. Also, the policy indicated activity programs were designed to encourage maximum individual participation and were geared to the resident's needs.	F 679		
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756 SS=F	Continued From page 37 CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 38 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a process for the director of nursing and medical director to review all pharmacy consult recommendations for 5 of 5 residents (R3, R4, R6, R14, R25) reviewed for unnecessary medications. This practice had the potential to affect all 28 residents residing in the facility. Findings include: On 3/28/18, at 8:38 a.m. the director of nursing (DON) provided a black book with a Monthly Drug Therapy Review sheet for each resident residing in the facility. The form had three columns for the date, pharmacist signature and comment. The form had pharmacy consultant notes in the comment column and it was not always clear if it was a personal note for the pharmacist or if a separate recommendation was left and required a review. R3's Monthly Drug Therapy included monthly reviews from 10/11/17 to 3/13/18. The review listed two comments for recommendations from the consulting pharmacist. There was no indication the recommendations were reviewed by the DON or medical director. R4's Monthly Drug Therapy included monthly reviews from 1/27/17 to 3/13/18. The review included five pharmacy recommendations to be reviewed. There were no indication these recommendations were reviewed by the DON or medical director.	F 756	F Tag 756 Drug Regimen Review It is the policy of Wood Dale Home is to have a Drug Regimen Review, Report Irregular, Action on &.. The drug regimen of each resident must be reviewed at least one a month by a licensed pharmacist&. This review must include a review of the resident□s medical chart. The pharmacist must report any irregularities to the attending physician and the facility□s medical director and director of nursing.& What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Regarding R4, R6, R14, R25, and R3 the DON will review the pharmacy recommendations and have the medical director review and sign the pharmacy recommendations and add to resident□s charts making any changes if needed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice; Upon receiving a pharmacy recommendation the receiving nurse will review and fax to primary physician, after the order is signed, a copy will go into the resident chart and the original will go to the DON for review, the DON will review recommendation, sign,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 39 R6's Monthly Drug Therapy included monthly reviews from 7/20/17 to 3/13/18. The review included one pharmacy recommendation to be reviewed. There were no indication the recommendations were reviewed by the DON or medical director. R14's Monthly Drug Therapy included monthly reviews from 1/26/17 to 3/13/18. The review included two pharmacy recommendations to be reviewed. There were no indication the recommendations were reviewed by the DON or medical director. R25's Monthly Drug Therapy included monthly reviews from 1/26/17 to 3/13/18. The review included one pharmacy recommendation to be reviewed. There were no indication the recommendations were reviewed by the DON or medical director. During interview on 3/28/18, at 8:52 a.m. the DON stated there was no formal process for herself or the medical director to review the pharmacy consultant's recommendations. The DON stated it was important to ensure follow through on the recommendations were completed. When interviewed via telephone on 3/30/18, at 12:36 p.m. the consulting pharmacist (CP) stated she writes up her recommendations and lets the director of nursing know how many recommendations she has. She then hands the recommendations to the nurse in charge for the day to have them addressed. Currently there was no process for the DON and medical director to review the recommendations she makes. She would work on implementing a process with the	F 756	then place in folder for medical director to review and sign during monthly rounds. The signed copy is then placed in chart. Regarding the process by which the pharmacist logs the recommendations both the pharmacist and DON will meet to discuss options for a more thorough and clear documentation process by May 7th 2018. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The revised policy for Drug Regimen Review will be reviewed and revised then presented at IDT for feedback. Additional revisions will be made if necessary by May 7th 2018 How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The Drug Regimen Review policy will be reviewed annually and revisions will be made as needed. Licensed staff will be trained regarding policy changes by May 7th 2018 DON and IDT will audit Pharmacy review log monthly x 2 months IDT will audit Pharmacy Recommendation Forms to ensure Medical Director and DON have reviewed and signed each recommendation monthly x 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 40 facility as she had done at other facilities. During interview via telephone on 3/30/18, at 4:00 p.m. the medical director stated he did not review the consulting pharmacist recommendations. The facility Pharmacy Consultant Expectations Policy dated 2017, did not include how the consulting pharmacist would ensure the DON and medical director would review the pharmacy consultants recommendations.	F 756	Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physician-ordered laboratory test was completed for 1 of 5 residents (R25) reviewed for unnecessary medications. Findings include: R25's quarterly Minimum Data Set (MDS) dated 3/9/18, identified intact cognition and included diagnoses of heart failure and hypertension. During observation on 3/27/18, at 8:44 a.m. R25	F 770	F Tag 770 Laboratory Services It is the policy of Wood Dale Home to provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services&. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Communication was sent to R25□s primary physician updating him on current condition and that we had missed the lab,	5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 41 was seated in his wheel chair in the dining room for breakfast. R25 was wearing socks and his feet were resting on the wheel chair foot rest. R25's feet and ankles showed no indication of any swelling. R25's communication to physician fax dated 1/21/18, indicated the following: Resident has 4+ edema in lower extremities, occasional SOB (shortness of breath) with transfers, lungs are clear and has no cough. Have been trying to keep resident in bed to elevate legs, but refuses. Will sit in recliner, but won't recline fully. What are your thoughts? The doctor's response was: Lasix (diuretic medication) 40 mg (milligrams) daily. BMP (Basic metabolic profile - a blood test to measure status of a person's kidneys and electrolyte and acid/base balance) in 1 week. R25's physician's orders dated 1/23/18, included a medication order for Lasix 40 mg's by mouth daily. R25's medical record lacked evidence a BMP was completed following the initiation of the Lasix medication on 1/23/18. When interviewed on 3/29/18, at 1:10 p.m. the director of nursing (DON) stated she would check the nursing calendar to see if there was a "yellow dot" placed by R25's order for a BMP, which would mean the lab was drawn, and also call the clinic to see if the lab results were not sent or misplaced. The DON stated R25 had heart failure, and the lab request would be typical to monitor a resident's response to Lasix, and the facility would also monitor for edema and weight gain.	F 770	PCP rescheduled lab draw for 4/24. Lab has been added to administration record per facility policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice; Upon receiving an order for a lab, the charge nurse will review the order, enter the order into the residents Administration record for the date indicated and selecting documentation necessary to ensure that the order must be signed off using the charge nurses personal electronic signature when completed. The charge nurse will also place on the nurse calendar and the 24-hour shift report. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The revised policy for laboratory services will be presented at QA for our medical director and other QA team member to review for necessary changes. Licensed staff will be educated on Laboratory Service Policy by 5/7/18. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 42 During a subsequent interview on 3/29/18, at 1:38 p.m., the DON stated she called the lab, however, they did not have anything on record for a BMP for R25. The DON stated after a brief investigation, she found R25's lab order was accidentally crossed off on the calendar, with a tiny message next to it that read "we still need." The DON stated the lab "unfortunately got missed" and R25 would still need a BMP. A facility policy regarding laboratory orders was requested, but none was provided. The facility provided a document, Point Click Care Cheat Sheet, undated, which listed step-by-step instructions on how to enter a new medication, or diagnostic laboratory test order.	F 770	assurance system. DON will audit Laboratory results and follow up monthly x2 months. Necessary follow up will be addressed, and concerns will be presented at IDT and QAA for feedback from Medical Director, Pharmacy Consultant, and other team members at next QAA meetings in May and August for further recommendations. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the quality assurance (QA) team developed and revised a quality improvement program to correct identified	F 867	F Tag 867 It is the policy of Wood Dale Home have a Quality assessment and assurance. Wood Dale□s quality assessment and	5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 43 resident care issues related to the the high numbers of urinary tract infections and the failure to implement an infection control process. This had the potential to affect all 28 residents residing in the facility. Findings include: On 3/29/18, at 12:43 p.m. the administrator and the director of nursing (DON) reviewed the last two Quality Assurance (QA) meeting minutes from 11/14/17 and 2/13/18. The documents identified the meetings were held quarterly and the required members were present at the meeting. The current Quality Improvement (QI) measures for 7/17-6/18 were new or worsening pressure sores. A review of infection control tracking and trending was not provided in the meeting minutes, nor was it identified in the topics to be reviewed. A narrative document titled Infection Control 2017 identified of the 11 infections identified in November, six of the infections were noted to be urinary tract infections (UTI's) which were treated with antibiotics. Of these infections, four of the infections identified organisms for E.coli (an organism found in the gastrointestinal tract with infections contributed to contamination from feces) to Klebsiella. It was noted in the report tow cultures identified no organism. Although the documented indicated two cultures did not identify organisms, there was no documentation to reflect what follow up action was taken. The documentation also did not indicate any further interventions implemented or training needs identified and completion of subsequent training. A narrative report titled Infection Control December 2017 identified four of the six	F 867	assurance committee does : Develop and implement appropriate plans of action to correct identified quality deficiencies; What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Individual Residents Not Identified. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The quality assurance process will develop a plan of action to identify resident care issues related to high number of urinary tract infections and implement an infection control process. The Quality Assurance Committee, at is next meeting in May, will review the tracking and trending of infections, including urinary tract infections. Documentation of such trending and tracking and follow up process and corrective and/or follow up actions recommended by committee will also be documented in minutes. Committee will identify further interventions/actions to be implemented and training needs identified and recommended. The Infection Control narrative report will be reviewed by the committee so that the infection control report does identify tracking and/or trending of symptoms and does identify potential training needs and follow through with assessments and audits. A narrative summary is recommended for the monthly Infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 44 infections reported in December were noted to UTI's presenting with symptoms of urgency, frequency, increased agitation, pain, somnolence, confusion and falls. The narrative report did not identify the organisms, however, the tracking sheet identified two of the four infections were identified as e. coli. The report failed to identify any patterns noted in the reporting from the consecutive months. The report did not identify any tracking or trending of symptoms and did not identify potential training needs and follow through with assessments and audits. An infection control log of January 2018 was presented without a summary listing and it was noted out of 10 infections identified, five were noted to be UTI's, with one resident have a change in antibiotics as culture identified the organism was resistant to one of the medication. Of the five UTI's listed, two of the organisms identified were E.coli, with the remaining three infections lacking identification of organisms. Upon review of program concerns identified with the infection control program, the increased number of urinary tract infections, and the current antibiotic stewardship the DON stated they had currently initiated only one project for QIIP and this was not the project implemented. The administrator stated information information regarding the current infection control rates were presented in January 2018; however, no formalized plan had been developed, adding this would be a project in the future. At this time, the infection control nurse had not been participating in the QA meetings. A facility policy titled Quality Assurance and Performance Improvement Plan, dated 12/16 , identified the purpose of the QAPI was to utilize	F 867	Control report for presentation to the QA Committee. Also the Infection Control Preventionist designee is expected to participate and attend the quarterly QA Committee meetings. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The IDT Team will meet weekly to review resident data and identified concerns such as infections, adverse events, use of antibiotics, resident or family concerns as shared or identified by team members. The IDT Team will bring a summary of audits, data, concerns to report to the quarterly Quality Assurance Committee for review and recommendations. The Quality Assurance and Performance Improvement Plan will be reviewed and revised as needed by the interdisciplinary team prior to May 7, 2018. The next quarterly Quality Assurance Committee meeting including the medical director, pharmacist, and other members will be held in May, 2018. Policies to be reviewed and revised will include: Quality Assurance and Performance Improvement (QAPI) Program/Plan and Committee. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 45 detail driven, proactive approach to improving the quality of life, quality of care and service. The QAPI program was to identify opportunities for improvement, address gaps in systems and processes, develop and implement improvement or corrective plans, and continuously monitor for effectiveness of of planned changes.	F 867	implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. I Team will meet prior to each quarterly QAA meeting and prepare for presentation to QAA committee data collection and/or Performance Improvement Projects from the previous 3 months. Topics and audits for the next quarterly meeting in May to include infection control tracking and trending, recurring infections specifically UTI□s, use of antibiotics, resident participation in preferential activities, choices in AM/PM cares, as well as other newly identified areas by the interdisciplinary team. Newly identified areas or areas needing continuous or further improvement will be addressed at the subsequent quarterly meetings of August and November. QAA committee will be held responsible for undertaking systematic changes that are needed to improve or maintain identified areas. QAA committee will assist with root cause analysis, giving feedback for problem solving and monitoring systems to strive for sustained improvements. Resources of supplies and equipment, staff training, revised processes and policy updates will be recommended by the QAA committee at each quarterly meeting. Medical Director and Pharmacist will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 46	F 867	recommend to the Interdisciplinary team any suggestions or recommendations they would have for improved clinical care, quality of life and resident choice with their monthly visits or more often if needed. Quality Assurance and Performance Improvement Plan will be reviewed annually. Who is responsible for this plan of correction? Administrator or her designee will be responsible for compliance. Date of Correction: May 7, 2018	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively analyze their infection trending and implement corrective actions for identified infection issues in the facility. This had the potential to affect 28 of 28 residents. In addition, the facility failed to ensure signage was posted outside resident rooms and written instruction posted that identified what personal protective equipment to implement for 1 of 1 residents (R13) whom had contact precautions. Findings include: INFECTION CONTROL PROGRAM The Infection Control Log Wood Dale Nursing Home dated December 2017, identified four urinary tract infections (UTI). Organisms identified were two E-Coli, one strep and one organism was not identified. The corresponding infection analysis included a graph and indicated 67 percent of facility infections were UTI's. The analysis failed to identify any trending or patterns	F 880	F Tag 880 Infection Prevention & Control It is the policy of Wood Dale Home to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and F Tag 880 Infection Prevention & Control It is the policy of Wood Dale Home to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents found to be affected: R13's Care plan has been updated to identify all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 in the UTI's or address actions taken by the facility to reduce the prevalence of UTI's. In addition, the facility also did not address actions taken to ensure organisms were identified for UTI infections. The Infection Control Log Wood Dale Nursing Home dated January 2018, identified five upper respiratory infections (URI) and four UTIs. Urinary bacterial organisms identified were one E. Coli, one E. Faecalis, one organism was not identified, and one organism was identified as just bacteria. The corresponding analysis identified URI transmission between two residents who sat at the same dining table. Analysis stated one way to prevent transmission of infection could be to isolate residents that show symptoms until they have undergone antibiotic treatment or were 24 hours from being febrile. The analysis failed to indicate if the facility took actions to prevent or reduce transmission of URI's. Further, the analysis failed to identify any trending or patterns in the UTI's or address actions the facility took to reduce the prevalence of UTI's. In addition, the facility also did not address actions taken to ensure organisms were identified for UTI infections. The Infection Control Log Wood Dale Nursing Home dated February 2018, identified five UTI's. Four UTI organisms identified were E.coli, and one organism was S. Aureus. The corresponding analysis identified two case of E. coli were located down the 100 wing, and the other two E. coli cases were down the 300 wing. Further, the residents were frequently to totally incontinent. The IP added a statement of "I can only assume that good handwashing was not being followed" and felt the occurrence of UTI's was "too high."	F 880	transmission based precautions related to the MRSA infection. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice; Residents who require contact precautions per our infection control policy will have signage posted in an area visible prior to entering room giving direction to staff and visitors what PPE is needed, care plan will be updated to identify transmission-based precautions necessary when providing care to the resident. Education and training will be provided on following subject on 4/25 & 5/1 • Hand Washing • Quick path UTI • Antibiotic stewardship • Isolation precautions • Contact precautions surveillance is implemented to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. • The criteria for such infections will be based on the current standard definitions of infections. • Infections that will be included in routine surveillance include those with ¿ Evidence of transmissibility in a healthcare environment ¿ Clinically significant morbidity or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50 The analysis lacked any actions taken by the facility to reduce the prevalence of UTI's. On 3/29/18, at 3:33 p.m. the Infection Preventions registered nurse (RN)-A stated the February 2018, analysis identified hand-hygiene contributed to UTI's. UTI's were an ongoing concern in the facility. RN-A explained the facility provided hand hygiene education during a staff meeting sometime around the beginning of the year; however the education did not include any return demonstrations and was not mandated by all staff to attend. She tried to get all the culture reports; however at times they were not received, but it was better than it was. RN-A felt that overall, handwashing training was effective, even though the incidents of UTI's did not decrease. RN-A did not complete audits to assess training effectiveness and re-evaluate approaches. RN-A identified two employees who repeatedly were noncompliant with handwashing both before and after the staff meeting, however, no corrective action was completed for improper hand hygiene. RN-A verbalized facility infections were addressed at monthly meetings, which she attended. Further the facility infections were reviewed quarterly at Quality Assessment and Assurance (QAA) meetings; however, she was not invited to attend the QAA meetings. When interviewed on 3/29/18, at 4:49 p.m. the DON stated she was aware of staff noncompliance with gloving and handwashing. Further, the concerns were not addressed directly with employees not in compliance. DON stated she felt singling out one staff was not appropriate but addressed hand hygiene and the importance of wearing gloves at a staff meeting. DON confirmed there was no record of hand hygiene	F 880	mortality associated with infection (e.g., pneumonia, UTIs, c.difficile);and ¿ Pathogens associated with serious outbreaks. (e.g., invasive streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza). • The infection Prevention & Control designee will analyze for trending and patterns and identify similarities in infections including but not limited to UTI's and URI's, findings will be presented at IDT, and QA to address necessary action/interventions to be taken and guidance from medical director and pharmacy consultant to reduce the prevalence of such infections. • The infection prevention & Control designee along with IDT & QA members will document the actions/interventions taken and their effectiveness and determine any follow up action as necessary. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility will utilize formal training webinars/seminars and other training tools from Lake Superior presented to Infection Prevention and Control-RN and other staff members as appropriate to ensure knowledge and understanding of infection control requirements and ability to carry them out. The Infection surveillance data including but not limited to infection log (staff and residents), site map, graphs, trends and patterns, actions taken, follow up, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 51 training at the staff meeting. DON confirmed hand hygiene was not audited following the meeting to ensure staff compliance. DON stated not following good hand should have addressed directly with individuals who were noncompliant. Furthermore, employee training was not mandatory, and attendance was an issue. Management was working to ensure staff received training by having in-services at times to promote attendance and to call them directly to inform them that attendance is required. The QAA was planning on doing a process improvement project on UTI's; however they had not started this. CONTACT PRECAUTIONS R13's quarterly Minimum Data Set (MDS) dated 2/6/18, identified R13 had moderate cognitive impairment and admitted to the facility with a Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough) with an infection to the foot. Diagnoses included a multi-drug resistant organism (MDRO) infection and dementia. R13's WOC (wound, ostomy, continence) Provider Documentation dated 11/8/17, identified R13 had an ulcer on her left foot with a methicillin resistant staphylococcus aureus (MRSA) MDRO infection. On 3/18/18, the WOC nurse indicated R13 continued with MRSA to the left foot ulcer. R13's care plan revised 11/16/17, identified R13 had a pressure ulcer related to ill- fitting shoes. The care plan indicated she was followed by wound care and the wound was not healing due to an MRSA infection. The care plan did not identify any transmission based precautions	F 880	outcome/effectiveness of previous actions will be presented by Infection Control Prevention-RN at IDT every Wednesday for review, feedback, and guidance from team members. Interventions and follow up will be documented for each affected resident in medical record, documentation will be labeled “Infection Note” to improve ease of follow up. Infection Control prevention-RN will present a summary of findings at quarterly QAA for further feedback and guidance from our Medical Director, Pharmacy Consultant, and other team members. How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The infection control surveillance data including but not limited to infection log (staff and residents), site map, graphs, summaries of trends, interventions, follow up, documentation and outcomes will be audited bi-monthly x 2 months at IDT. Data will then be presented at QAA for review and feedback from Medical Director, Pharmacy Consultant and other team members in May and August. Hand Washing; All staff will complete hand washing competency by May 7th, yearly , upon hire, and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 related to the MRSA infection, or when the precautions were implemented. During observation on 3/26/18, at 4:20 p.m. R13's room had two metal covered bins. The bin on the left had a yellow bag and the cart on the right had a yellow bag. Another cart in the corner of R13's room had gowns and gloves. There was no notification on the outside of R13's room to alert visitors or staff of infection precautions. At 7:20 p.m. R13 was seated in her wheelchair in the common area. R13 had blue gripper socks on both feet and her feet were resting on the wheelchair foot pedals. During interview on 3/27/18, at 2:14 p.m. nursing assistant (NA)-A stated R13 had a MRSA infection in her foot. She was on contact precautions and anytime the staff came in contact with her foot they were required to gown and glove. NA-A stated R13's dressing to her left foot was intact and never leaked. On 3/27/18, at 2:41 p.m. nurse practitioner (NP)-A and the WOC nurse (WN)-A were onsite to do R13's wound care. NP-A stated R13 had a chronic MRSA infection in her left foot pressure ulcer and contact precautions (used for infections, diseases, or germs that are spread by touching the patient or items in the room, which include gowning and gloving.) were required with wound care and any time staff would come into contact with her foot. NP-A and WN-A both gowned and gloved upon entering R13's room. Following wound care both NP-A and WN-A removed their gloves followed by their gowns and disposed of them in the appropriate infection control covered bins in R13's room, washed their	F 880	Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53	F 880		

hands and left the room.

During interview on 3/28/18, at 12:43 p.m. NA-B stated gowns and gloves needed to be worn whenever coming into contact with R13's foot or changing he bedding. NA-B stated she was verbally given instruction on R13's contact precautions.

When interviewed on 3/29/18, at 11:32 a.m. licensed practical nurse (LPN)-A stated anytime staff had contact with R13's foot or room linens they needed to follow contact precautions by wearing a gown and gloves. Further, R13's care plan did not give specific instructions for the staff to follow, nor was there an infection precaution alert posted outside R13's room for visitors or staff.

At 11:35 a.m. registered nurse (RN)-A stated staff should be aware R13 was on precautions because she had infection control carts in her room. A posting to alert residents, visitors and staff was not posted because it was a "dignity" issue. She did not know why contact precautions and when to use them were not included on R13's care plan.

At 2:36 p.m. the director of nursing (DON) stated staff were told about precautions in report. The facility had contact precaution signs to be posted outside residents rooms who were on precautions, but the facility had not been using them. Further, the DON stated it was important to have clear instruction for visitors and staff on R13's contact precautions to prevent the spread of infection.

The facility Infection Prevention and Control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 54 Manual Transmission Based Precautions policy dated 2017, included contact precautions. Contact precautions included gloving and gowning. The policy did not address contact precaution signs that identified what PPE was needed when caring for this resident.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed ensure urinary tract symptoms were appropriately treated for 1 of 2 residents (R28) reviewed for urinary tract infections. Findings include: R28's significant change Minimum Data Set (MDS) dated 1/22/18, identified R28 was cognitively intact and required extensive assistance with toileting and personal hygiene. R28 was frequently (7 or more episodes of urinary incontinence, but at least one continent void) incontinent of bladder and always continent of bowel. R28's progress notes identified the following:	F 881	F Tag 881 Antibiotic Stewardship Program It is the policy of Wood Dale Home to maintain an Antibiotic Stewardship Program. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R28□s concerns related to this issue have resolved. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For other residents who may be affected by this practice; Staff will be trained on	5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 55 - 12/23/17, at 6:52 a.m. R28's urine had a "rancid" strong odor. Was without fever and had complaints of burning with urination. Further, R28 was confused. The physician was contacted and received and order for a urinalysis (UA) with urinary culture (UC) if indicated. - 12/23/17, at 12:59 p.m. Results of UA were called to the physician. The physician prescribed Ciprofloxacin (Cipro) (antibiotic) 500 milligrams (mg) twice a day (BID) for five days. R28's UA lab report dated 12/23/17, identified R28's urine was light yellow and clear. The UA identified leukocyte esterase (white blood cells) 2+ with a negative result. All other urine values were negative. The UA was set up for a culture. R28's physician order dated 12/23/17, directed staff to administer Cipro 500 mg by mouth BID for 2+ leukocyte esterase in the urine for five days. R28's UC lab report dated 12/25/17, indicated greater than 100,000 colonies of bacteria per milliliter (col/ml) which were mixed probable contaminants. The UC did not grow any bacteria and was negative. R28's medical record lacked communication to the physician; R28's UC was negative for a bacterial infection, and direction for continuing the antibiotic prescribed for a urinary tract infection. R28's December 2017, TMA (trained medication aid) Administration Record identified R28 received all 10 doses of Cipro 500 mg as prescribed by R28's physician on 12/23/17. During interview on 3/28/18, at 2:45 p.m.	F 881	and required to use the Loeb criteria which includes " Acute dysuria or " Fever >100. Or increase of 2.4 degrees grater than base line And at least one of the following New or worsening " Urgency " Frequency " Suprapubic pain " Gross hematuria " Costovertebral angle tenderness " Urinary incontinence Once criteria is met, communication to physician will be made requesting UA with reflex culture Monitoring for continued or worsening UTI s/s will be started, Charge nurse will schedule in admiration record a Time Out which includes 1. Check for new, worsening, or relief of symptoms 2. Has the culture been completed and is the resident on the appropriate antibiotic? 3. Update physician of findings and confirmation that antibiotic should be continued. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Training will be provided to staff by the Infection Prevention and Control designee Policy will be presented to IDT for review and feedback, updates will be made as necessary By May 7th,2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 56 registered nurse (RN)-A stated it was a frequent practice for physicians to prescribe antibiotics while awaiting the results of a urine culture. R28's physician should have been contacted about discontinuing her Cipro order as R28 did not have a bacterial infection to warrant the use of the antibiotic and not to wait for the physician to address it. On 3/29/18, at 8:27 a.m. the director of nursing (DON) stated results of urine cultures were always forwarded to the physician for review. The nurses have not been asking for an order to stop antibiotics inappropriately prescribed, because it was up to the physician to address the continued use of antibiotics. The antibiotic stewardship program in the facility was a work in progress and she had just talked to RN-A about developing a antibiotic time out process to review antibiotics for appropriate use; however, the process had not been fully developed and in use yet. The undated facility Antibiotic Stewardship Policy identified a mission to promote the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use.	F 881	How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. IDT will review infection log and audit process used for infection identification, treatment, and follow up with physician monthly x 2 months. Policy will be presented at QAA for feedback from Medical Director, Pharmacy Consultant, and other team members in May and August Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: May 7th 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	**600 SUNRISE BOULEVARD** **REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Wood Dale Home Incorporated was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	**600 SUNRISE BOULEVARD** **REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Wood Dale Home Incorporated is a one-story building with no basement. It was constructed in 1976, is fully fire sprinkler protected and was determined to be of Type II(222) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has single-station, battery operated smoke alarms in all Resident Rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	**600 SUNRISE BOULEVARD** **REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a licensed capacity of 40 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT met by evidenced by:	K 000		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) FINDINGS INCLUDE: Based on observation and documentation review,between 10:00 AM and 1:00 PM on 03/28/2018, documentation could not be located	K 926	K926 Gas Equipment – Qualifications and Training Staff concerned with the application, maintenance and handling of medical gases and cylinders will be retrained on the risk. Northwest Respiratory, our oxygen supply vendor, has provided a training video for use in retraining our staff. Training of our staff will be scheduled and completed by May 7, 2018 Completion date: May 7, 2018 Person Responsible: Environmental Director and Human Resource Director	5/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD DALE HOME INC	**600 SUNRISE BOULEVARD** **REDWOOD FALLS, MN 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 3 to show that all staff that handle gas cylinders have received safety training guidelines and usage requirements of gas cylinders per NFPA 99. This deficient practice was verified by the Facility Maintenance Director.	K 926		