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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NBHZ

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 **12/31/2013** (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 **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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):

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective December 8, 2013, the facility is certified for 50 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Kathy Sass, HPR Dietary Specialist — 12/31/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/04/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
12/24/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245261

February 5, 2014

Ms. Judith Sandmann, Administrator
Wood Dale Home Inc.
600 Sunrise Boulevard
Redwood Falls, Minnesota 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 December 8, 2013, the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6169

****This letter serves to correct and replace the letter dated January 31, 2013.****

February 5, 2014

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

RE: Project Number S5261024

Dear Ms. Sandmann:

On November 21, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 31, 2013. 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 December 31, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 13, 2013 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 October 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 31, 2013, effective December 8, 2013 and therefore remedies outlined in our letter to you dated November 21, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File
Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245261	A. Building B. Wing	12/31/2013

Name of Facility	Street Address, City, State, Zip Code
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **12/08/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/08/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/08/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/08/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/08/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/08/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/08/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** BF/KJ	**Date:** 1/14/2014	**Signature of Surveyor:** 31223	**Date:** 12/31/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/31/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245261	A. Building 01 - MAIN BUILDING 01 B. Wing	12/13/2013

Name of Facility	Street Address, City, State, Zip Code
WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	11/18/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By BF/KJ	Date: 1/31/2014	Signature of Surveyor: 31223	Date: 12/13/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/31/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NBHZ

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 **10/31/2013** (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 **50** (L18)

13.Total Certified Beds 50 (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NEII — 12/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen Leach, Program Specialist — 12/18/2013 (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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7616

November 21, 2013

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

RE: Project Number S5261024

Dear Ms. Sandmann:

On October 31, 2013, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>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;

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

Informal Dispute Resolution - 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 a "F" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (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 December 8, 2013, 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 December 8, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 31, 2014 (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 May 1, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

WOOD DALE
600 SUNRISE BOULEVARD
REDWOOD FALLS, MINNESOTA 56283

December 9, 2013

Attention: Karen

Minnesota Department of Health
Brenda Fischer, Unit Supervisor
3333 West Division, #212
St. Cloud, Minnesota 56301

Re: Project Number S5261024

Addendum for Plan of Correction for Survey Completed October 31, 2013

F278

Case Managers were educated on monitoring for accuracy between the direct care charting on Care Tracker System, the Charge Nurse nurses notes, with verbal interviews of staff when variations are found. Two random audits of the MDS and the CAA's will be completed each month over the next three months to review for accuracy of the assessment findings and the MDS coding.

F323

Assist rails will be inspected by environmental staff with assistance of RN for the potential for entrapment with the use of the bed rail, including measurements of spacing of the rails in relation to the bed and mattress. FDA Zones 1-4 will be audited for meeting the specific measurement and documented for each resident rail initially. Random audits of five assist rails will be completed weekly for three months.

If you have any further concerns or questions, please contact me. Thank you for your assistance in modifying our Plan of Correction.

Sincerely,

Judy Sandmann, Administrator

12/9/13

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 _____	10/31/2013

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 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable POC 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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	See Attached 12/9/13 BA - See addendum	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Landmann Adm | TITLE | (X6) DATE: 12-3-13

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 _____ B. WING _____	10/31/2013

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F 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident assessment accurately reflected the resident condition and care for 2 of 3 residents (R9 and R47) reviewed for urinary incontinence. Findings include: R9's admission Minimum Data Set (MDS) was inaccurately coded for a toileting program. R9's admission MDS dated 8/1/13, indicated R9 was always incontinent of urine, a toileting program had been trialed without improvement, and was not currently on a toileting program. R9's Care Area Assessment (CAA) dated 8/5/13, indicated R9 was "unable to feel the urge to void and doesn't ask to to use the bathroom, will put on call light if needs to be changed." R9's Bowel and Bladder Assessment dated 7/31/13, included R9 was always incontinent of urine. The assessment failed to identify any type of trialed toileting program. When interviewed on 10/30/13, at 12:30 p.m.	F 278		

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F 278	Continued From page 2 registered nurse (RN)-A stated normally when a resident is admitted, they will automatically place them on an every two hour toileting schedule to assist in determining voiding patterns and needs, the nurse aides document this, and RN-A would use this information to aid in determining a toileting plan for each resident. The two hour trial would be coded on the MDS as a toileting program. However, R9 had never been placed on the two hour program. RN-A did not know why the 8/1/13, MDS indicated a toileting program had been tried, as none had. R47's quarterly MDS dated 9/10/13, inaccurately reflected R47's urinary continence status. R47's diagnosis included diabetes. R47's admission MDS dated 6/17/13, identified the resident was cognitively intact and was always continent of urine. However, R47's quarterly MDS dated 9/10/13, indicated R47 was occasionally incontinent. R47's nursing assistant documentation for the assessment reference period 8/31/13 through 9/6/13, indicated one episode of urinary incontinence on 9/2/13. R47's care plan dated 6/18/13, indicated R47 was independent with personal hygiene and continent of bowel and bladder. When interviewed on 10/30/13, at 1:15 p.m.,	F 278		

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F 278	Continued From page 3 registered nurse (RN)-A stated R47 is continent of bowel and bladder, has never been incontinent of urine, does not wear incontinent products, and "he would have said something to someone if he did have an accident." RN-A further stated, "I did this MDS, and usually I would put a note explaining that it was a coding error [the 9/2/13 incontinent episode], he should not have been coded this way [as occasionally incontinent]." A bladder assessment policy was requested, but not provided by the facility.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	See Attached	

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 2 residents (R38) who had a change in ambulation ability, and for 1 of 2 residents (R9) who had developed a pressure ulcer. Findings include: R38's care plan was not updated when her ambulation program was discontinued. R38's diagnoses included osteoporosis and dementia. The quarterly Minimum Data Set (MDS) dated 10/18/13, included severe cognitive impairment, was dependent upon staff for activities of daily living (ADL's), but did not ambulate. R38's care plan dated 10/22/13, included use of a standing lift for transfers, and "walks with restorative ambulation program." R38's Functional Maintenance Restorative Program form dated 8/15/13, included, "discontinue program due to: unsafe to ambulate..." When interviewed on 10/30/13, at 9:10 a.m. registered nurse (RN)-A stated R38's care plan should have been updated when the ambulation program had been discontinued, but she had	F 280		

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F 280	Continued From page 5 missed it. A policy was requested, but not provided by the facility. R9's care plan was not updated when she developed a pressure ulcer. R9's diagnosis included end stage renal (kidney) disease. The admission MDS dated 8/1/13, included she was at risk for pressure ulcers, but did not have a pressure ulcer. R9's Body Audit form dated 7/24/13, included, "She has approx [approximately] 1 inch reddened slit on buttocks-very fragile open skin." R9's care plan dated 8/5/13, included, "At risk for pressure ulcers related to needing extensive assist with bed mobility." R9's goal was, "[R9's name] will have no pressure related skin conditions thru [through] 11/13." Staff were instructed to use a pressure-reducing cushion in wheel chair and on 8/28/13, a low air loss mattress was added to her bed. The care plan failed to identify R9 had an open area on buttocks, or what cares to provide to aide in healing. When interviewed on 10/30/13, at 12:35 p.m. RN-A stated when R9 was admitted she had an excoriated buttocks, therefore they had not initially recognized the open area was a pressure ulcer. On 8/24/13, the facility had identified the area as a pressure ulcer and a treatment plan	F 280		

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F 280	Continued From page 6 was developed. RN-A stated the care plan should have been updated at that time, but was not. When interviewed on 10/30/13, at 1:00 p.m. the director of nursing (DON) stated R9's care plan should have been updated with her current skin condition of a pressure ulcer. A facility policy entitled Policy and Procedure for the Prevention and Treatment of Skin Breakdown, dated 2010, included under number two, "If a resident is admitted with or there is a new development of a pressure ulcer...the following procedure is to be implemented... 9. Update Care Plan for Skin Integrity..."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care planned interventions for 1 of 2 residents (R29) reviewed who utilized an alarm system to aid in fall prevention. Findings include:	F 282	SEE ATTACHED	

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F 282	Continued From page 7 R29's diagnosis included dementia. The quarterly Minimum Data Set (MDS) dated 10/21/13, included severe cognitive impairment, required extensive assistance with transfers and ambulation, but had not fallen. The Care Area Assessment (CAA) dated 8/2/13, included R29 had fallen on 7/23/13 and sustained a pelvic fracture prior to admission. R29's care plan dated 8/2/13, included, "At risk for falls related to history of falls." Staff were instructed to use a "TABS alarm (A brand name alarm that has a string attached to the resident at one end and a magnet that attaches to a monitor at the other end, the monitor attaches to a stationary object. When the resident gets up, the magnet detaches and an alarm sounds.) on wheelchair and in bed as she attempts to self-transfer." R29's Safety Risk Evaluation dated 7/29/13, included, "had couple falls prior to admission, had fall with fractured pelvis, unable to stand with [sic] -using 2 staff and standing lift. Working with therapy-is at increase risk R/T [related to] psychoactive medication use." The assessment further indicated problems with balance and a decline in functional status. R29 was observed on 10/28/13, at 3:50 p.m. sitting in a recliner in the day room. A TABS was attached to the back of her shirt, but the monitor was just lying on the arm of the recliner. At 4:20 p.m. R29 had put the foot of the recliner down and was attempting to launch her upper body	F 282		

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F 282	Continued From page 8 forward, multiple times, to get out of the chair. Licensed practical nurse (LPN)-A was notified R29 was attempting to get out of the recliner by herself and her alarm monitor was not attached to anything. LPN-A stated the monitor should be attached to the chair, or it would not sound when R29 got up. R29 was observed on 10/29/13, at 9:45 a.m. being transferred, with two nurse aides and a transfer belt, into the recliner in the day room. After the transfer the TABS monitor was tucked into the arm of the recliner. Nursing assistant (NA)-B stated the alarm should be attached to something, " it is hard with this chair," she then used the clip on the back of the monitor and attached it to the fabric towards back of recliner, securing it. R29 was observed on 10/29/13, at 3:20 p.m. in the dining room, however, the TABS alarm was lying on the recliner in the day room. LPN-A was notified and stated R29 should have the alarm on all the time, she then retrieved the TABS alarm and applied it to R29's shirt and secured the monitor to the back of her wheel chair. R29 was observed on 10/31/13, at 10:15 a.m. sitting in the recliner in the day room, the TABS monitor was lying on the arm of the recliner, not attached to anything. Trained medication aide (TMA)-A was notified and she stated the alarm doesn't need to be attached to anything. If R29 were to stand up, the magnet would pull off the monitor box and it would sound. The alarm was then held by the string and did not come apart	F 282		

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F 282	Continued From page 9 and alarm until it was shaken vigorously. TMA-A did not attach the alarm to anything. At 10:23 a.m. Registered nurse (RN)-A and the director of nursing (DON) were notified the monitor had not been attached to anything. RN-A secured the monitor to a garbage can placed behind the recliner. The String Monitor pamphlet from the manufacturer was provided by the DON on 10/31/13, at 11:00 a.m. The DON stated this is what they call a TABS alarm. The pamphlet included under Patient Set-Up and Use, "1. Securely mount the pull-string monitor to a wheelchair using he clip on the back of the monitor. If using a bed, clip the monitor to the optional bed mounting bracket." The directions did not indicate how to secure the monitor to a reclining chair.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately identify,	F 314	See Attached	

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F 314	Continued From page 10 assess, monitor interventions, and revise interventions as needed, for 1 of 2 residents (R9) reviewed who had pressure ulcers. Findings include: R9's diagnoses included pressure ulcer, urinary tract infections, and end stage renal (kidney) disease for which she received renal dialysis. R9's admission Minimum Data Set (MDS) dated 8/1/13, included moderate cognitive impairment, bowel and bladder incontinence, required extensive assistance with bed mobility and total staff assistance with transfers. R9 was at risk for pressure ulcers, but did not have a pressure ulcer. R9's Care Area Assessment (CAA) dated 8/5/13, included R9 was at risk for pressure ulcers related to needing assistance with bed mobility, "Tissue Tolerance showed no signs of concern at this time," and was placed on an every four hour repositioning program. R9 was observed in bed, with a low air loss mattress, head of bed elevated approximately 60 degrees on 10/29/13 from 9:00 a.m. until 10:15 a.m. and 3:00 p.m. until 4:00 p.m. With head of bed elevated approximately 45 degrees on 10/30/13 from 7:00 a.m. until 8:15 a.m. and 10/31/13 from 7:50 a.m. until 8:30 a.m. R9 was observed in a recliner chair, that was slightly reclined on 10/29/13, from 2:00 p.m. until 3:00 p.m. and 10/30/13, from 8:15 a.m. until 11:15 a.m., and 10/31/13 from 8:30 a.m. until 11:00 a.m.. R9 was repositioned anywhere from	F 314		

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F 314	Continued From page 11 every hour to every 3 hours. When interviewed on 10/30/13, at 12:00 p.m. nursing assistant (NA)-C stated R9 was to have her incontinent pad changed every four hours and repositioned at that time. However, NA-C stated R9 gets uncomfortable before the four hours is up and will want to be repositioned more often. She stated that R9's incontinent product is often very saturated when she is changed. When interviewed on 10/30/13, at 12:00 p.m. nursing assistant (NA)-C stated R9 was to have her incontinent pad changed every four hours and repositioned at that time. However, NA-C stated R9 gets uncomfortable before the four hours is up and will want to be repositioned more often. She stated that R9's incontinent product is often very saturated when she is changed. When interviewed on 10/30/13, at 3:00 p.m. R9 stated she has a sore on her buttocks that had been there "a long time," she stated she thought it was getting better, it "doesn't hurt very much." R9 refused to have the surveyor observe the open area on her coccyx. Review of the medical record identified R9's Body Audit form dated 7/24/13, included, "She has approx [approximately] 1 inch reddened slit on buttocks-very fragile open skin." A Clinical Assessment of Skin Conditions on the back side of the Body Audit form indicated "impaired/decreased mobility and decreased functional ability, end stage renal disease,	F 314		

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F 314	Continued From page 12	F 314		

cognitive impairment, urinary and fecal incontinence, and moisture related skin damage." Even though R9's Body Audit revealed skin integrity concerns, this had not been reflected on the 8/1/13 MDS and CAA.

Review of R9's Tissue Tolerance Data Worksheet dated 7/30/13 included, "Small abrasion coccyx area that was present @ [at] admission. Area is healing, no other open areas or skin breakdown, follow every 2 hr/prn [two hour and as needed] repositioning schedule." There was no indication if this area was a pressure ulcer, or the same "moisture related damage," as identified on the 7/24/13 Body Audit form.

R9's Braden Scale for Predicting Pressure Sore Risk form dated 7/31/13, identified R9 had problems with Skin exposed to moisture, very moist; mobility limitations of chairfast; probable inadequate nutrition; and a problem with friction or shearing of tissue. R9 was identified on this form as being at moderate risk for pressure ulcers. The form was updated on 8/5/13, 8/20/13, 9/3/13, 10/1/13, 10/7/13, and 10/18/13 with the same results.

R9's care plan dated 8/5/13 included, "At risk for pressure ulcers related to needing extensive assist with bed mobility." R9's goal was, "[R9's name] will have no pressure related skin conditions thru [through] 11/13." Staff were instructed to use a pressure-reducing cushion in wheel chair, and on 8/28/13, a low air loss mattress was added to her bed. The care plan indicated staff should reposition her with toileting.

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F 314	Continued From page 13 R9's toileting care plan indicated this was to occur every four hours, even though R9's Tissue Tolerance Data Worksheet indicated a two hour repositioning would be implemented. The care plan did not identify R9 had an open area on her buttocks, and was to be repositioned every two hours as assessed on the Tissue Tolerance Data Worksheet dated 7/24/13. A fax to R9's physician dated 8/24/13, identified, "Resident has open area on coccyx measuring 1.9 cm [centimeters] x 0.9 cm. Set up treatment to cleanse area with soap and water, wipe with skin prep and apply Allevyn foam dressing until resolved." Review of R9's Body Audit forms dated 8/20/13, 9/3/13, and 9/25/13, identified an open area or slit on coccyx but did not describe the size, staging, exudate, pain, wound bed or a description of the wound edges or surrounding tissue to ensure adequate monitoring was being completed. There was no other monitoring of the pressure ulcer, beside the body audit form during this time frame. Review of R9's Weekly Wound Documentation Progress Sheet initiated on 10/1/13, identified R9 had a stage two pressure ulcer on their coccyx. The wound measured at 1.2 cm by 0.9 cm, with a wound bed that contained 100% slough [necrotic tissue, usually light in color], a scant amount of serous [clear] drainage, with pink wound edges, "Slit on coccyx that is open..." The National Pressure Ulcer Advisory Panel defines a stage 2 pressure ulcer as, "Partial	F 314		

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	245261	A. BUILDING _____ B. WING _____	10/31/2013

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 314	Continued From page 14 thickness loss of dermis presenting as a shallow ulcer with a red pink wound bed..." The wound was again assessed on 10/8/13, 10/16/13, and 10/29/13, with improvement in wound noted. R9's Redwood Area Hospital discharge notes dated 10/19/13, identified a pressure ulcer on her coccyx measuring 2.5 by 1.5 cm. On 10/29/13, the pressure ulcer measured 1 cm by 0.4 cm, depth superficial, no drainage present. Review of R9's Medication Sheet dated 8/24/13 included, "Open area on coccyx, cleanse with soap and water, skin prep Allevyn, change every 3 days." No treatment to this area was initiated prior to this date, even though the 7/24/13, Body Audit form indicated R9 had an open area on coccyx. This treatment continued being signed out throughout September, except during R9's hospitalization 9/11/13 through 9/25/13, when it was changed to a different dressing, Duoderm, after her hospital return. R9's Medication Sheet starting 8/30/13, included, "Apply Calmoseptine [protectant ointment] to sore bottom q shift [every shift] until healed." This was signed out each shift until hospitalized on 9/11/13 through 9/25/13, and then resumed. When interviewed on 10/30/13, at 12:35 p.m. registered nurse (RN)-A stated R9 was admitted she had an excoriated buttocks, therefore they had not initially recognized the open area was a pressure ulcer. On 8/24/13 when physician was faxed about the open area, it would have been a	F 314		

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F 314	Continued From page 15 stage two pressure ulcer and a low air loss mattress was placed on R9's bed to aid in pressure prevention. However, RN-A had not evaluated any other risk factors R9 had such as skin being, "very moist," problem with shearing, or limited mobility. RN-A had not re-assessed R9's every four hour check and change or repositioning program, even though R9's skin was "very moist." RN-A could not find any documentation indicating R9 had ever had an excoriated buttocks, only the actual open area had been identified in the medical record. When interviewed on 10/30/13, at 1:00 p.m. the director of nursing (DON) stated R9 had been initially admitted with the pressure ulcer, but the staff did not recognize it as a pressure ulcer. A few weeks ago a facility consultant was in and directed the DON to take over monitoring of pressure ulcers, as staff had missed identifying this one. The DON could not find any documentation that R9 had ever had any excoriation of her buttocks. The DON stated R9 should have been re-assessed for her check and change and repositioning frequency, as the pressure ulcer had not healed and R9's incontinent product was often saturated on the current schedule. The problem of "shearing" could occur related R9 often having the head of her bed up and using the recliner, but this had not been evaluated. The DON stated R9's care plan should have been updated to reflect the actual pressure ulcer along with interventions to aid in healing. A facility policy entitled Policy and Procedure for the Prevention and Treatment of Skin	F 314		

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F 314	Continued From page 16 Breakdown, dated 2010, included under number two, "If a resident is admitted with or there is a new development of a pressure ulcer...the following procedure is to be implemented: 1. Initiate Wound Care Protocols...5. Notify Therapy Department for seating surface evaluation and possible treatment interventions...6. Re-evaluate turning and repositioning intervals; initiate a new Turing and Reposition Observation form...7: Initiate Braden Scale and Comprehensive Risk Data Collection form. 8. Re-evaluate interventions per risk factors identified. 9. Update Care Plan for Skin Integrity..." Even though the facility was aware R9 had an open area on her coccyx on 7/24/13, they failed to implement the two hour incontinent product change and repositioning schedule as had been assessed on 7/30/13. The facility did not reevaluate R9's turning and repositioning schedule, nor was consistent monitoring completed so different interventions could be implemented to assist in healing R9's pressure ulcer, when previous interventions were unsuccessful.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315	See Attached	

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F 315	Continued From page 17 function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident had a comprehensive urinary incontinence assessment to prevent skin breakdown for 1 of 3 residents (R9) reviewed with urinary incontinence. Findings include: R9's diagnoses included chronic kidney disease, recurrent urinary tract infections, and pressure ulcer. The admission Minimum Data Set (MDS) dated 8/1/13, indicated moderate cognitive impairment, required extensive assistance for toileting and hygiene, and received a diuretic (water pill) daily. The MDS further indicated R9 was always incontinent of urine, a toileting program had been trialed without improvement and was not currently on a toileting program. R9's Care Area Assessment (CAA) dated 8/5/13, indicated R9 was "unable to feel the urge to void and doesn't ask to to use the bathroom, will put on call light if needs to be changed." R9 was observed in bed, 10/29/13 from 9:00 a.m. until 10:15 a.m. and 3:00 p.m. until 4:00 p.m. She was again observed in a recliner chair, on 10/29/13, from 2:00 p.m. until 3:00 p.m. and 10/30/13, from 8:15 a.m. until 11:15 a.m., and 10/31/13 from 8:30 a.m. until 11:00 a.m.. R9 was not toileted during these time frames.	F 315		

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F 315	Continued From page 18 When interviewed on 10/30/13, at 12:00 p.m. nursing assistant (NA)-C stated R9 was suppose to have her incontinent product changed every four hours, however R9 gets uncomfortable before the four hours is up and will request to be changed more often. R9's incontinent product is usually saturated with urine when it is changed. When interviewed on 10/31/13, at 9:00 a.m. R9 stated she is aware when she urinates, but has little control over it. She stated she had been incontinent for about the past year, but had not had any testing, but has problems with her kidneys and gets urinary tract infections a lot. When interviewed on 10/31/13, at 9:40 a.m. NA-A stated R9's will often put on her call light and request an incontinent product change about every three hours, R9's brief was usually completely saturated each time. R9's Body Audit form dated 7/24/13 included, "She has approx [approximately] 1 inch reddened slit on buttocks-very fragile open skin." R9's fax to physician dated 8/24/13, included, "Resident has open area on coccyx measuring 1.9 cm [centimeters] x [by] 0.9 cm. Set up treatment to cleanse area with soap and water, wipe with skin prep and apply Allevyn foam dressing until resolved." R9's Bowel and Bladder Assessment dated 7/31/13, included: R9 had been incontinent of urine since admission. Contributing diagnoses to incontinence included "kidney disease, mental	F 315		

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F 315	Continued From page 19 illness, and behaviors." Medications contributing included anti-psychotics, calcium channel blockers, and narcotics. Required a mechanical lift for transfers and was confined to a chair. The assessment further indicated pain did not contribute to elimination pattern. The assessment concluded with R9 had "functional" incontinence and would be placed on an every four hour check and change program for her incontinent brief. The assessment failed to identify if R9 had been incontinent prior to admission/illness, if R9 had a history of urinary tract infections, if she had any signs of urinary retention, any voiding pattern, use of a diuretic, pattern of fluid intake, use of any caffeine, any physical features that may contribute to urinary incontinence, or any current skin breakdown. R9's medical record revealed she had been hospitalized on 9/11/13 and on 10/19/13 with urinary tract infections. R9's Weekly Wound Documentation Progress Sheet dated 10/1/13, indicated R9 had a stage two (partial tissue thickness loss) pressure ulcer on her coccyx. R9's Bowel and Bladder Assessment was updated on 10/7/13, 10/18/13, and 10/30/13, and acknowledge R9 had current skin breakdown on buttocks and a history of urinary tract infections. Even though the assessment identified skin breakdown and UTI's, the plan of care for R9 was not changed to address these concerns and continued with an every four hour toileting schedule. The assessment also did not evaluate R9 incontinence prior to admission, use of a diuretic, pattern of fluid intake, use of caffeine, urinary retention or any physical features that may	F 315		

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F 315	Continued From page 20 contribute to R9's incontinence. R9's care plan dated 8/5/13, included, "Toileting deficit related to needing total assistance with toileting." R9's goal was listed as, "Skin condition will improve with no signs of moisture associated skin damage by 11/13." Staff were instructed to, "Check and change [incontinent product] Q 4 hours [every four hours]." When interviewed on 10/30/13, at 12:30 p.m. registered nurse (RN)-A stated normally when someone is admitted, they will automatically place them on an every two hour toileting schedule to assist in determining voiding patterns and needs. The nurse aides document this and they would use this information to assist in determining a comprehensive toileting plan for each resident. This had not been completed for R9. RN-A did not know why the 8/1/13, MDS indicated a toileting program had been tried, as none had, nor was any voiding pattern determined. RN-A stated they had not performed any physical assessment on R9 to see if any abnormalities were contributing to urinary incontinence or if R9 had any urinary retention, even though R9 had developed two urinary tract infections since admission. There was no indication that R9 voided large amounts at one time, or small amounts, or if she had continuous leakage of urine, that contributed to her skin condition. There was no indication that R9's "check and change" frequency of every four hours had been reassessed even though R9 developed a pressure ulcer while in the facility. RN-A was unaware of how frequent R9's incontinent product was wet, or if this contributed to her skin	F 315		

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F 315	Continued From page 21 breakdown. Even though the facility had placed R9 on an every four hour "check and change" program for her incontinent product, R9 had skin breakdown and urinary tract infections, and the facility failed to re-assess if the four hour program remained appropriate for R9. A bladder assessment policy was requested, but not provided by the facility.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assist rails fit the bed properly to reduce entrapment risk for 1 of 3 residents (R29) reviewed who utilized assist rails. Furthermore, the facility failed to maintain safe water temperatures in 6 of 30 resident rooms/bathrooms, this had the potential to affect 18 residents (R11, R14, R12, R27, R47, R42, R31, R25, R38, R18, R44, R20, R23, R4, R36, R41, R13 and R35) who were identified by the facility at risk for potential burns related to the	F 323	See Attached	

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F 323	Continued From page 22 facility hot water temperatures. Findings include: R29's assist rails exceeded the recommended spacing in zones 3 and zones 4, as recommenced in the current U.S. Department of Health and Human Services Food and Drug Administration (FDA) guidance for Bed System Dimensional and Assessment Guidance to Reduce Entrapment, issued 3/10/06. R29 had not been assessed to determine if she could use these assist rails on her bed safely. R29's medical record identified diagnosis of dementia. The quarterly Minimum Data Set (MDS) dated 10/21/13, included severe cognitive impairment, required extensive assistance for bed mobility, transfers, ambulation and her balance was not steady and required physical assist to stabilize. R29's care plan dated 8/2/13, included under "At risk for pressure ulcers..., 2 grab bars on bed to assist with bed mobility." " Is able to self-transfer out of bed and walk to bathroom per self at times." Under, "At risk for falls related to history of falls," included to use a TABS [brand name] alarm on wheelchair and in bed as she attempts to self-transfer." During observation on 10/28/13, at 3:50 p.m. R29 was sitting in the day room. R29 was unable to answer simple questions. R29's bed had a Halo Safety Ring grab bar on each side of her bed.	F 323		

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F 323	Continued From page 23 R29's mattress was slid over against the left grab bar, which left a gap of 4.75 inches between the mattress and the grab bar (zone 3) on the right side. This also left a gap between the end of the rail/ under the rail and the mattress support platform (zone 4) of 4.0 inches. Both of these gaps were potential areas of entrapment of the neck or body between the rail and the mattress and at the end/under the rail and the mattress support platform. R29's Evaluation for Use of Side Rails dated 7/29/13, and updated 10/21/13, indicated assist rails had been placed on R29's bed on 7/24/13. The assessment indicated the rails were being used for safety, security and bed mobility. The rails were to assist R29 with bed mobility, transfers, and avoid rolling out of bed. The assessment failed to identify if R29 would be safe using these rails, with the large gap in zones 3 and 4. The director of nursing (DON) and registered nurse (RN)-A acknowledged the large gap between the mattress and rail, and under the rail and the mattress support on 10/28/13, at 6:30 p.m. and replaced R29's bed. The DON agreed this gap may not be safe for R29 as she is confused, had a history of falls, with poor balance and strength. During interview with the maintenance director (MD) on 10/31/13, she stated she had moved R29's bed a few weeks ago and the HALO rails were snug against the mattress at that time. MD stated when R29 pushes the HALO rails, it	F 323		

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F 323	Continued From page 24	F 323		

loosens the screw under the bed and the rails separate, coming further apart. This was a design flaw in how the rails attach to the bed. MD does rounds monthly to check and be sure all rails fit the beds properly. This had been an issue with these particular rails and she had brought it to the DON's attention several times. However, the facility continued to utilize these rails for several residents.

The Halo Safety Ring Instructions sheet, undated, from the manufacture included Installation Steps. Installation step number 5 included, "Eliminate all space between the mattress frame and the Halo Safety Ring Mount Bracket..."

A facility policy entitled Bed Safety, dated 11/12/12, included under number 2. "To try an prevent deaths/injuries from the beds and related equipment, the facility shall promote the following approaches. a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risk and problems including potential entrapment risks. b. Review that gaps within the bed system are within the dimensions established by the FDA. d. Ensure that bed side rails are properly installed using the manufacture's instructions and other pertinent safety guidance to ensure proper fit. 9. Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails."

Safe water temperatures were not maintained in 6 of 30 resident rooms/bathrooms, with the potential to affect 18 residents that were identified by the facility as being at risk for sustaining

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F 323	Continued From page 25 potential burns. During observation on 10/28/2013, between 4:00 p.m. and 6:00 p.m., the following water temperatures were noted: Room 100 was 123.3 degrees F (Fahrenheit); room 110 was 121.8 F; room 111 was 122.7 F; room 201 was 123.6 F; room 205 was 121.8 F; and room 309 was 122.9 F. A review of facility incident and accident reports from 8/1/2013 to 10/28/2013 indicated there were no residents that sustained burns or had incidents related to use of hot water temperatures in the facility. During an interview on 10/28/2013 at 7:45 p.m., the facility administrator, and director of nursing, confirmed there had been no burn-related incidents in the facility regarding hot water temperatures. On 10/28/2013 at 8:06 p.m., the director of maintenance, (DM) verified water temperatures in rooms 111 and 309 were 121 F and lowered the water heater thermostat 10 degrees at that time. At 8:15 p.m., the DM stated that during the summer, when the air conditioning was on, the water heater thermostats needed to be adjusted "up" to maintain hot water temperatures. The DM explained that the water pipes and air conditioning pipes laid "side by side in the ceiling," and the water cooled as a result. A week ago, the air [air conditioning] was turned off, and the building heat was turned on, but the thermostat for the water heater was not turned down, and this was the reason why the water temperatures in the rooms were high. Following	F 323		

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F 323	Continued From page 26 the DM's adjustment of the water heater thermostat on 10/28/2013 at 8:15 p.m., the facility tracked water temperatures from a sample of resident room and common areas at various times throughout the day and evenings, between 10/28/2013 and 10/31/2013. The room water temperatures ranged between 111 and 115 degrees Fahrenheit. A review of the facility Water Temperature Weekly Checklist indicated that between 8/1/2013 and the 10/19/2013, resident room and shower/tub area water temperatures ranged between 94 and 97 degrees Fahrenheit. There were no temperatures logged between 10/20/2013 and 10/26/2013, the third week of October. On 10/31/2013 between 9:00 and 9:40 a.m., the DM took water temperatures from a sample of rooms closest to and farthest from the hot water source on each of the facility wings, as well as from each of the common resident bathing rooms. During this time, the water temperatures ranged between 102 and 115 degrees Fahrenheit. At 9:40 a.m. the DM stated that during her absence from the facility "last week", the air conditioning system in the building was turned off, which resulted in the elevated temperatures of the water in resident rooms. The DM felt the elevated water temps noted on Monday "were corrected," and that a new sheet to track and log temps was in place. The DM also verified the water temperatures had the potential to affect R11, R14, R12, R27, R47, R42, R31, R25, R38, R18, R44, R20, R23, R4, R36, R41, R13 and R35. During an interview on 10/31/2013 at 9:55 a.m.,	F 323		

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 _____	10/31/2013

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 323	Continued From page 27 the facility administrator acknowledged the water temps "were a little out of range on Monday," and said a new way of tracking resident room water temperatures was already begun. The director of nursing confirmed on 10/31/13 at approximately 11:00 a.m. there were 18 residents (R11, R14, R12, R27, R47, R42, R31, R25, R38, R18, R44, R20, R23, R4, R36, R41, R13 and R35) at risk for sustaining potential burns from the facility hot water temperatures. Review of facility policy Safety and Supervision of Residents, revised 11/12/2012, indicated that the facility "... strives to make the environment as free from accident hazards as possible." The policy recognized "water temperatures" as an environmental risk factor and hazard. The policy did not contain any specific measures or direct facility actions in regard to ensuring safe water temperatures in resident rooms.	F 323		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	See Attached	

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 _____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 441	Continued From page 28 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to track or trend employee infections, and compare these to resident infections, to determine any potential cross contamination. This had the potential to affect all 30 of 30 residents currently in the facility. Findings include: The facilities Infection Control Log (s) were	F 441		

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 _____	10/31/2013

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

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F 441	Continued From page 29 reviewed from 1/1/13, through 10/25/13, and contained resident infection tracking. Summary Reports were also conducted each month for surveillance and trending of resident infections. The facility had not provided any tracking system for employee infections, nor noted if any employee infections were related to resident infections in the Summary Reports. When interviewed on 10/31/13, at 10:30 a.m. the administrator stated she tracks employee infections on a weekly basis, however, she was not tracking the illness type and did not compare employee infections with resident infections to determine any patterns or if the infections were related in any way. A policy was requested, but not provided by the facility.	F 441		

F Tag 278 Assessment Accuracy/Coordination/Certified

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For resident R9 and R47 the case manager reassessed urinary incontinence to accurately reflect the residents current condition and developed an individualized care plan.
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 case manager will review and revise elimination plan as needed.
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 and procedure for bowel and bladder was reviewed and revised by the interdisciplinary team on 11/27/13. New assessment forms for bowel evaluation and bladder evaluation were implemented. Staff members were trained as it relates to their respective roles and responsibilities regarding the policy and procedure. Licensed staff meeting is scheduled for 12/4/13.
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.	Three toileting assessments will be audited randomly for the next three months. The results will be reported to the QAA Committee at the next quarterly meeting for review and further recommendation.
Who is responsible for this plan of	

correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/8/13

F Tag 280 Right to Participate Planning Care-Revise Care Plan

It is the policy of Wood Dale Home to develop a comprehensive care plan and to revise the care plan periodically.

The resident does have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

The facility must develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R9, the care plan was reviewed and revised to include interventions related to pressure ulcers. For Resident R38, the care plan was reviewed and revised regarding the discontinuation of the restorative ambulation program Corresponding updates have been made to care assignment sheets.
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 have been reviewed and revised by case managers. Nurse aide care plans were reviewed and revised as needed. Education will be provided to licensed nursing staff scheduled for 12/4/13.
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 for Care Plans will be reviewed by the interdisciplinary team on 11/27/2013. Staff members were trained as it relates to their respective roles and responsibilities regarding care plans.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan	Three care plans will be audited randomly each month for three months. Results reported to the QAA Committee at their next scheduled meeting for review and further recommendations.

must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/08/2013

F Tag 282 Comprehensive Care Plans (Qualified Persons)

It is the policy of Wood Dale Home to provide care and services by qualified persons in accordance with each resident's written plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R29, care plan was reviewed with staff for their appropriate follow through.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents at the facility are at risk to not have their care plans implemented as written. For the facility residents who have deficit needs identified as a part of their MDS assessment, the current care plan interventions identified to assist the resident will be monitored for proper implementation. This will be done by observational audits.
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 Comprehensive care plans will be reviewed by the interdisciplinary team on 11/27/2013. Staff will be in serviced by the DON as to their responsibility to implement these policies and individual resident care plans scheduled for 12/3/13.
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.	Random observation audits will be conducted twice per week for two weeks and randomly monthly for two months. Staff conducting the audits will be inserviced by the Director of Nursing as to corrective action to be taken onsite and documentation of the findings related to the specific staff observed so that DON can take further action if needed. Audit findings will be shared with QAA Committee at its next scheduled meeting for review and make further recommendations.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance.

	Date of Correction: December 8, 2013

F Tag 314

It is the policy of Wood Dale Home that based on the comprehensive assessment of a resident, to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R9, individualized repositioning schedules to maintain skin integrity and to heal pressure ulcers have been developed. Case Managers have reviewed the care plans and have developed an individualized repositioning schedule to maintain skin integrity based upon the tissue tolerance assessment.
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 case managers have reviewed the care plans for identified residents with skin integrity issues for proper interventions.
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 and procedure for Prevention and Treatment of Skin Breakdown was reviewed and revised by the interdisciplinary team on November 27, 2013. Case Managers and interdisiciplinary team were trained as it relates to their respective roles and responsibilities. Licensed staff training scheduled for 12/4/13.
How the facility plans 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	Three random audits of skin assessments will be completed every month for the next three months. The results will be reported to the QAA Committee at the next quarterly meeting for review and further recommendation.

system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/8/1013.

F Tag 315

Based on the resident's comprehensive assessment, Wood Dale Home does ensure that –

A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

And a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R9, Case Manager reassessed her urinary incontinence and developed an individualized elimination plan.
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, the case managers have reviewed their toileting plans for appropriate interventions.
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 and procedure for bowel and bladder was reviewed and revised by the interdisciplinary team on 11/27/13. New assessment forms for Bowel Evaluation and Bladder Evaluation were implemented. Staff members were trained as it relates to their respective roles and responsibilities regarding the policy and procedure. Licensed staff meeting scheduled for 12/4/13.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan	Three toileting assessments will be audited randomly monthly for the next three months. The results will be reported to the QAA Committee at the next quarterly meeting for review and further recommendation.

must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/8/1013.

F Tag 323

Wood Dale Home does ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R29 a new side rail assessment was completed and implemented. Care plans were revised and updated. Environmental Director, with the guidance of the installing plumber, reset the temperature on the water heater to a lower temperature to ensure water temperatures are maintained at a safe level for all of those residents who are capable of accessing water in their rooms. Logs of water temperatures taken in the 6 noted rooms have been maintained since October 29, 2013, on a weekly basis.
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 with assist rails, case managers reassessed the use of the assist rails. For those residents assessed to be safe without the assist rails, the assist rails were removed. For those residents assessed to need the assist rails, the assist rails were inspected to assure they fit the bed properly. Care plans were reviewed and revised as needed. Water temperatures will be taken and logged for the identified resident rooms to ensure that the water temperatures are maintained at a safe level for the residents who are capable of accessing water in their resident rooms.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The assessment form for assist rails was updated to better assess each resident to reduce the potential for entrapment risk. Interdisciplinary staff were trained on November 27, 2013 as it relates to their respective roles and responsibilities regarding the policy and procedure for unnecessary medications. The procedure for monitoring water temperatures in resident rooms will be reviewed and revised by the environmental staff.

How the facility plans 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 Side Rail Assessments reviews will be completed weekly for four week, and then randomly monthly for three months, utilizing the MDS and Care Conference quarterly schedule to ensure continued compliance. The results will be reported to the QAA Committee at their next scheduled meeting for review and further recommendation. Water temperature logs will be reviewed weekly for three months. Results will be reported to QAA Committee at their next scheduled meeting for further review and further recommendation.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance, with assistance from the Environmental Director for the water temperatures. Date of Correction: 12/8/1013.

F Tag 441 Infection Control, Prevent Spread, Linens

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.

(a) Infection Control Program The facility must establish an Infection Control Program under which it

(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens – Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Facility Employee Infection Control Surveillance Employee call in logs and schedules will be reviewed to include symptoms of infections when applicable. Data will also be summarized for trending and correlation to the Resident Infection Control for Surveillance data. for communication and discussion of these trends and patterns of resident infections at Quality Assurance meetings.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Interdisciplinary Team will review infection control log monthly and analyzed the information and look for trends to prevent the spread of any infections. Staff will be educated when symptomatic on whether they should work or not.
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 and procedure for Infection Control Surveillance was reviewed and revised by the interdisciplinary team on 11/27/2013. A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Licensed nursing staff have been trained on the

	surveillance of infections at Wood Dale Home.
How the facility plans 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.	Infection Control Log audits will be completed following each two week schedule for three months. Results will be reported to the QAA Committee for review and further recommendations at their next scheduled meeting.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/08/2013

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 _____	10/31/2013

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	K 000		

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 FORM 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, on October 31, 2013. At the time of this survey, Wood Dale Home Incorporated was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

POC ok
FB 12-2-13

DE: 12-10-13

EXIT: 10-31-13

RECEIVED
DEC 2 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Dannhauer Adm.	12-1-13	

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 _____	**10/31/2013**

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

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K 000	Continued From page 1 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@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. The facility has a licensed capacity of 50 beds and had a census of 32 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		

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 _____	10/31/2013

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

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K 062	Continued From page 2 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system in accordance with the provisions at NFPA 101 (2000) Chapter 19 and NFPA 13 (1999). In a fire emergency, this deficient practice could adversely affect 50 of 50 residents, staff and visitors. FINDINGS INCLUDE: On 10/31/2013 at 10:19 AM, observation revealed the water pressure gauge on the fire sprinkler system riser was marked with the date 6/5/08. In a subsequent interview with facility staff, it was confirmed this was the most recent date the gauge had been replaced, and no documentation could be provided verifying the fire sprinkler system gauge had been recalibrated or replaced within the previous five (5) years. This deficient practice was not in accordance with the requirements at NFPA 25 (1998 edition) Chapter 2, Section 2-3.2.	K 062	K062 The water pressure gauge On the fire sprinkler system Was replaced on 11/18/13 by Tyco Simplex Grinnell. Completion Date: 11/18/13 Environmental Director Kristi Senkyr is responsible.	

SERVICE REQUEST

FORWARD TO YOUR ACCOUNTS PAYABLE DEPARTMENT

tyco SimplexGrinnell

SR# [illegible] | Page ____ of ____

TK# [illegible]

[illegible] Plymouth, MN [illegible]
P 763-[illegible]
F 763-[illegible]

CUSTOMER LOCATION:			System left in service __✓__ yes ____ no	BILL TO:	
NAME [illegible]			Fire Department notified ____ yes ____ no	NAME	
ADDRESS [illegible] Blvd				ADDRESS	
CITY [illegible] Falls	STATE MN	ZIP	______ vehicles w/ tools $81.00 per day	CITY STATE ZIP	
PHONE 507-[illegible]	CONTACT [illegible]		______ valve seals	PHONE	FAX

WE STRONGLY RECOMMEND IMMEDIATE CORRECTION OF ANY DEFICIENIES/ IMPAIRMENTS IDENTIFIED. WE URGE YOU TO NOTIFY THE LOCAL AUTORITY HAVING JURISDICTION AND YOUR INSURANCE CARRIER WITHOUT DELAY.

SimplexGrinnell, for and in consideration of the prices herein named, proposed to furnish the work, and/ or materials hereinafter described, subject to the terms and conditions outlined below.

I authorize SimplexGrinnell to proceed with the work as agreed to and outlined below:

____

CUSTOMER SIGNATURE DATE

SCOPE OF WORK: Gauge not [illegible] calibrated

WORK PERFORMED: Replaced water pressure gauge and 1/4 valve for gauge

LABOR / HOURS

DATE	NAME	ST	OT	DT
[illegible]	Jim [illegible]	3.5		

MATERIAL

DESCRIPTION	QTY	UNIT PRICE	

MATERIAL (continued)

DESCRIPTION	QTY	UNIT PRICE	
[illegible] gauge	1		
1/4 valve	1		

IMPORTANT NOTICE TO CUSTOMER

Customer acknowledges and agrees to the terms and conditions on the reverse side of this form, agrees that the services have been completed to the Customer's satisfaction and the system is in good working order, unless services performed were of a temporary nature, in which case Customer acknowleges that part of customer's system may be inoperable until service can be complete

CUSTOMER'S ATTENTION IS DIRECTED TO THE LIMITATION OF LIABILITY,WARRANTY, INDEMNITY AND OTHER CONDITIONS ON REVERSE SIDE

CUSTOMER AUTHORIZATION AND ACCEPTANCE

[signature]

(Customer Acceptance)

(Print Name)

SIMPLEXGRINNELL LP

[signature]

(SimplexGrinnell Representative)

(Print Name)

CUSTOMER COPY