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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RQZW

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 **1/26/2015** (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):

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 01/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 2/5/2015 (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
Posted 02/09/2015 Co.

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

CMS Certification Number (CCN): 245261
February 3, 2015

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective January 19, 2015 the above facility is certified for or recommended 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, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2015

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

RE: Project Number S5261025

Dear Ms. Sandmann:

On December 26, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 11, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 19, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 11, 2014, effective January 19, 2015 and therefore remedies outlined in our letter to you dated December 26, 2014, 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
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245261	A. Building B. Wing	1/26/2015

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **01/19/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/19/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/19/2015**
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	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: 2/3/2015	Signature of Surveyor: 10652	Date: 2/3/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/11/2014		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: RQZW

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 **12/11/2014** (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

X 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):

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 01/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/30/2015 (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
Posted 02/03/2015 Co

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 # 7010 1670 0000 8044 5322

December 26, 2014

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

RE: Project Number S5261025

Dear Ms. Sandmann:

On December 11, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

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

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

Remedies - 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
St. Cloud Survey Team A
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Brenda.fischer@state.mn.us

Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 20, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 March 11, 2015 (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 June 11, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5261s15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ MN Dept of Health St.Cloud B. WING _____	12/11/2014

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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	See Attached 1/14/15 POC accepted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judith A. Handmaker | TITLE: ADMINISTRATOR | (X6) DATE: 1-6-15 gs

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 _____	12/11/2014

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 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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 _____	12/11/2014

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 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notice of Medicare non-coverage in a timely manner to 1 of 3 residents (R37) reviewed for liability notices. Findings include: R37's interdisciplinary progress notes (PN) were revived from 7/27/2014 to 8/23/2014 and indicated the following: R37 was admitted to the local hospital on 7/27/14. R37 returned to the nursing home on 7/29/2014, and the PN indicated "resident arrived at 11:00 - [family member (FM)] is with - hospice here now doing an assessment. ..."] Since R37 had an order for hospice care, R37's nursing home care was reimbursed by hospice and Medicare part A no longer covered R37's care although R37 continued to remain in the facility.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3 Review of the record identified R37 had an Expedited Notice (CMS 10123) of non coverage, that identified R36 services would end on 7/27/14, due to hospice services on 7/27/14. The family signed the form on 8/12/14, 13 days after Medicare coverage had ended. The family also received the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form was signed by FM-B on 8/12/14, 13 days after Medicare coverage had ended. The last page of the SNFABN was left unmarked, and gave no indication of the FM's wishes to submit or not to submit to medicare for a appeal. A progress notes dated 8/12/14 indicated, "Called left [FM-A] a message to call me back re: medicare denial form that needed to be signed." There was no indication the family was contacted before the 8/12/14, which was 13 days after Medicare coverage ended. An interview on 12/10/14 at 11:30 a.m. accountant A stated, "I only store the forms, the DON gets the signature." During interview on on 12/10/14 at 11:52 a.m., the director of nursing (DON) stated R37 was covered by medicare part A and was changed to hospice as a payer. "I was on vacation at that time so I guess it [the SNFABN] didn't get signed." During an interview on 12/10/2014 at 12:13 p.m. the administrator said "The DON does the denials and the case manager acts in her place when she is gone." The facility policy regarding Medicare Part A Determination was requested but not provided.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 323	Continued From page 4	F 323		
F 323 SS=D	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 safe use of a rolling wheeled seated walker for 1 of 1 resident (R12) with a rolling walker; and failed to ensure 1 of 3 residents (R30) in the sample received adequate supervision and assistive devices to prevent accidents. Findings include: WHEELED WALKER: R12's quarterly Minimum Data Set (MDS), dated 10/27/14, identified she had intact cognition, required extensive assist of one staff for transfers, walks in room, corridor, and had no falls since last assessment. Review of the facility quarterly safety risk assessment dated 10/27/14, identified R12 was at high risk for falls. The facility functional and balance assessment dated 10/27/14, identified R12 was able to walk with staff assist and required the use of a walker.	F 323	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 _____	12/11/2014

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 323	Continued From page 5 During observations on 12/09/14, at 9:03 a.m., R12 was observed sitting on a wheeled walker seat, while nursing assistant -A (NA-A) pushed R12 backwards from the dining room to R12's room which was located at the far end of 100 wing hallway, which was approximately 100 feet. During interview at that time, R12 stated, "My arms got tired so I sat down and she pushed me. I usually don't sit on there. I usually walk." NA-A during this time stated she (R12) was tired does not walk by herself, so she had R12 sit down on the walker and get pushed. During interview on 12/9/14, at 3:00 p.m., R12 stated she ambulates with the wheeled walker in the hallway with staff help, when she is tired of walking she sits on the walker seat and staff push her in the walker. The above observation was discussed on 12/10/14, at 1:50 p.m., with the physical therapist-A (PT-A) who stated the only reason a seat was on wheeled walkers was for a resident to sit, if they became tired while walking. They could stop, put on the walker brakes, and sit down on the seat to rest before walking again. PT-A stated it was dangerous to be seated on the wheeled walker and pushed backwards. Seated wheeled walker were not to be used as a transport device, and only used for mobility During interview on 12/10/14, at 2:03 p.m., PT-A stated she expected staff to provide a wheelchair to transport R12 when too tired to walk, and use use the walker to transport R12. During interview on 12/10/14, at 2:33 p.m., PT-A stated the walker R12 used was a Midline Deluxe Rolling Walker.	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 _____	12/11/2014

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 6 During interview on 12/11/14, at 8:30 a.m., NA-C stated R12 usually ambulated with the wheeled walker to the dining room for lunch. When R12 became tired while ambulating, she sits down in a wheelchair which staff pulled behind while ambulating with R12. Review of manufacturer ' s instructions for Midline Deluxe Rolling Walker dated 1/23/09, safety instructions page 5 included the following: "Walkers are for individual use only and are NOT to be used as a wheelchair. DO NOT attempt to move the walker while you or anyone is sitting on the seat. DO NOT self-propel the walker while seated. Serious injury to you and/or damage to the walker frame or wheels may result from improper use. DO NOT use the seat to transport people or objects. DO NOT use the seat to carry or move anything." "DO NOT use the walker as a wheelchair." Operating Instructions page 13 included the following: Using as a seat: Push the walker into the position where you want to sit. LOCK the brakes BEFORE sitting. Safety Warnings: Also See Safety Instructions. "Before using the seat portion of your walker, ALWAYS lock the brakes FIRST. DO NOT navigate the walker while sitting on the seat. The brakes should always be locked when the seat is being used. Risk of fall and serious injury may result if brakes are NOT locked while the user is sitting on the seat." Review of facility policy for Walker, Ambulating With, dated 2008, made no mention of using a wheeled walkers with a seat as a transportation	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 _____	12/11/2014

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F 323	Continued From page 7 device. During interview on 12/11/14, at 10:20 a.m., director of nursing stated she expected staff not to use the seated wheeled walker for transport and not to transport the resident backwards. Staff should have used a wheelchair when R12 was tired ambulating and not the wheeled walker for transportation which was not safe for R12. PERSONAL ALARM: R30 had diagnosis that included dementia, psychosis, anxiety and depression according to facility face sheet. R30's quarterly Minimum Data Set (MDS), dated 10/17/14, identified cognitively impairment, required extensive assist of two staff for bed mobility and transfers, and had two falls since last assessment with no injury. The facility quarterly safety risk assessment dated 10/17/14, identified R30 was at high risk for falls. The facility functional and balance assessment dated 10/17/14, identified R30 had poor balance, and was not steady to stand, walk, transfer, or toilet. During observations on 12/10/14, at 8:40 a.m., R30 sat in a wheelchair in the dining room feeding self breakfast. At that time, activity aide-A (AA-A) sat down to assist R30 with breakfast. R30 had a personal alarm box in small cloth pouch clipped to the back of wheelchair, with the alarm cord was clipped to the back of wheelchair. The personal alarm cord was not connected to R30. During interview at that time, AA-A stated she not aware of what the personal	F 323		

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F 323	Continued From page 8 alarm box was for R30. During interview on 12/10/14, at 8:44 a.m., registered nurse-B (RN-B) confirmed the wheelchair personal alarm was not connected to R30 and RN-B connected the personal alarm cord to the back of R30's shirt. R30's care plan dated 10/20/14, identified R30 was at high risk for falls related to being unaware of safety needs, confusion, psychoactive medications, wandering, gait/balance problems, and incontinence. The goal was that R30 would not sustain serious injury through the review date. The interventions for this problem were to keep the environment safe with bilateral fall mats on the floor, anti-rollback device on wheelchair and personal alarm on R30's wheelchair. Document review of resident incident reports from 7/25/14 to 11/29/14, a period of six months, revealed R30 had 5 falls with no injury. Review of the most recent fall which occurred on 11/29/14, at 6:45 p.m., indicated R30 attempted a self- transfer out of recliner and fell. The incident report identified R30's personal alarm was not in place. During interview on 12/11/14, at 11:30 a.m., the director of nursing identified R30 had a history of falls and was a high falls risk. She stated R30 had a fall on 11/29/14, and the personal alarm was not connected to R30 when the fall occurred. She verified the alarms was used as an intervention for R30's falls, and expected staff to connect and use the personal alarm while R30 was in a wheelchair.	F 323		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=C	Continued From page 9 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nursing hours were posted in public view and failed to ensure changes were made to the	F 356	See Attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 10	F 356		

posting as changes occurred. This had the potential to affect all 29 residents residing in the facility.
Findings include:
During the initial facility tour on 12/8/14, at 2:20 p.m., social services-A (SS-A) stated the current facility census was 29 residents. During the initial tour, there was no evidence of any posting of required nursing hours.

During interview on 12/8/14, at 2:40 p.m., registered nurse-A (RN-A) was asked where the required nursing hours were posted. RN-A stated the hours were on the wall by the nurses ' desk behind the popcorn machine. The RN-A moved the popcorn machine away from the wall to show the surveyor the required nursing hours that were posted on a clip board behind the popcorn machine. The required staff hours posted stated 12/8/14 indicated census was 31 residents which was verified by RN-A. RN-A returned the clip board to the hook on the wall. The Social Services-A (SS-A) who was in the area moved the popcorn machine back into place which covered up the required posting. SS-A verified the required nursing hours were always posted on the wall behind the popcorn machine, making it difficult for anyone to visualize the required nursing hours.

Review of the posting direct care daily staffing numbers facility policy dated 8/2006, stated 1. " Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPN's, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. "

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F 356	Continued From page 11 During interview on 12/11/14, at 1:54 p.m., director of nursing verified the required posting of staff hours had not been visible that was located behind the popcorn machine.	F 356		

RECEIVED

JAN 07 2014

MN Dept of Health
St.Cloud

F Tag 156

It is the policy of Wood Dale Home to inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.....
It is the policy of Wood Dale Home to inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;.....
It is the policy of Wood Dale Home to inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.....
It is the policy of Wood Dale Home to furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, ...

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Resident R37 is no longer at this facility.
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, Director of Nursing will ensure that all medicare non coverage forms are filled out completely and timely. Social Service Designee will review and monitor follow through of completion of forms.
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 on Medicare Denial Letters Procedure has been reviewed and/or revised. Case Manager, as assistant to Director of Nursing, will be retrained on this policy and procedure to maintain compliance . Interdisciplinary team will also reretrained.
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	Audits of medicare denial notices will be conducted by Social Service weekly for four weeks and then randomly monthly for three months to ensure compliance with results reported to the QA/QI Committee for review and further recommendations.

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?	Social Service Designee will be responsible for compliance. Date of Completion: January 19, 2015

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 R12, facility and staff will ensure safe use of seated rolling walker. For Resident R30, facility and staff will ensure adequate supervision and use of assistive devices to prevent accidents. Care plans have been reviewed and revised.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Case Managers have reviewed other residents for the use of seated rolling walkers and personal alarms to prevent accidents. For those residents with tabs alarms, case managers will reassess the appropriateness of tabs alarm. For those residents assessed to need seated wheeled walkers, case managers will reassess the appropriateness of the wheeled walker. For those residents reassessed to need seated wheeled walkers or tabs alarms, case managers will audit to assure resident remains free of hazards and accidents weekly for four weeks and then randomly for three months.
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 "Walker, Ambulating With" and "Alarm Devices-Use of" were reviewed and revised by the Director of Nursing and Administrator. Staff members will be trained as it relates to their respective roles and responsibilities regarding the policies and procedures on 1/14/15.
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	Audits will be completed weekly for four weeks, and then randomly monthly for three months by the Interdisciplinary Team to ensure continued compliance. The results will be reported to the QAA Committee 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: 1/19/2015

F Tag 356 Nurse Staffing Information

It is the policy of Wood Dale Home to publicly post nurse staffing information at the beginning of each day, include the minimum data, and allow public access to posted nurse staffing data.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	The practice of posting hours was reviewed and revised on 12/24/14, changing the location of the posting. This will be further communicated to staff at licensed staff meeting onn 1/15/15 and next resident/family council meeting in January.
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 residents who may be affected by this practice, the hours posting will be reviewed by the Director of Nursing or designee each day to ensure proper listing of staff, facility, name, date, number of hours worked in each category and census is on the posting to ensure compliance.
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 "Posting Direct Care Daily Staffing Numbers" has been reviewed and revised by the Director of Nursing and Administrator on 12/24/14. Licensed staff will be trained as it relates to their respective roles and responsibilities on 1/15/15.
How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Audits of the hours posting will be completed by Social Service weekly for four weeks, randomly for three months. The results will be reported to the QA/QI Committee 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: 1/19/15.

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	245261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/10/2014**

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	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 10, 2014. At the time of this survey, Wood Dale Home Incorporated was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 29 at time of the survey.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5322

December 26, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5261025

Dear Ms. Sandmann:

The above facility was surveyed on December 8, 2014 through December 11, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer at the number or email listed above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File. 5261s15lic

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00749	A. BUILDING: _____ B. WING _____	12/11/2014

RECEIVED JAN 16 2014

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

MN Dept of Health St.Cloud

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 8th - 11th, 2014, surveyors of this Department's staff visited the above provider, and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders, and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Judy Landmann Adm. 4/15/15

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2 000	Continued From page 1 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe use of a rolling wheeled seated walker for 1 of 1 resident (R12) with a rolling walker; and failed to ensure 1 of 3 residents (R30) in the sample received adequate supervision and assistive devices to prevent accidents. Findings include: WHEELED WALKER: R12's quarterly Minimum Data Set (MDS), dated 10/27/14, identified she had intact cognition, required extensive assist of one staff for transfers, walks in room, corridor, and had no	2 830		

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2 830	Continued From page 2 falls since last assessment. Review of the facility quarterly safety risk assessment dated 10/27/14, identified R12 was at high risk for falls. The facility functional and balance assessment dated 10/27/14, identified R12 was able to walk with staff assist and required the use of a walker. During observations on 12/09/14, at 9:03 a.m., R12 was observed sitting on a wheeled walker seat, while nursing assistant -A (NA-A) pushed R12 backwards from the dining room to R12's room which was located at the far end of 100 wing hallway, which was approximately 100 feet. During interview at that time, R12 stated, "My arms got tired so I sat down and she pushed me. I usually don't sit on there. I usually walk." NA-A during this time stated she (R12) was tired does not walk by herself, so she had R12 sit down on the walker and get pushed. During interview on 12/9/14, at 3:00 p.m., R12 stated she ambulates with the wheeled walker in the hallway with staff help, when she is tired of walking she sits on the walker seat and staff push her in the walker. The above observation was discussed on 12/10/14, at 1:50 p.m., with the physical therapist-A (PT-A) who stated the only reason a seat was on wheeled walkers was for a resident to sit, if they became tired while walking. They could stop, put on the walker brakes, and sit down on the seat to rest before walking again. PT-A stated it was dangerous to be seated on the wheeled walker and pushed backwards. Seated wheeled walker were not to be used as a transport device, and only used for mobility	2 830		

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2 830	Continued From page 3 During interview on 12/10/14, at 2:03 p.m., PT-A stated she expected staff to provide a wheelchair to transport R12 when too tired to walk, and use use the walker to transport R12. During interview on 12/10/14, at 2:33 p.m., PT-A stated the walker R12 used was a Midline Deluxe Rolling Walker. During interview on 12/11/14, at 8:30 a.m., NA-C stated R12 usually ambulated with the wheeled walker to the dining room for lunch. When R12 became tired while ambulating, she sits down in a wheelchair which staff pulled behind while ambulating with R12. Review of manufacturer ' s instructions for Midline Deluxe Rolling Walker dated 1/23/09, safety instructions page 5 included the following: "Walkers are for individual use only and are NOT to be used as a wheelchair. DO NOT attempt to move the walker while you or anyone is sitting on the seat. DO NOT self-propel the walker while seated. Serious injury to you and/or damage to the walker frame or wheels may result from improper use. DO NOT use the seat to transport people or objects. DO NOT use the seat to carry or move anything." "DO NOT use the walker as a wheelchair." Operating Instructions page 13 included the following: Using as a seat: Push the walker into the position where you want to sit. LOCK the brakes BEFORE sitting. Safety Warnings: Also See Safety Instructions. "Before using the seat portion of your walker, ALWAYS lock the brakes FIRST. DO NOT navigate the walker while sitting on the seat. The brakes should always be locked when	2 830		

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2 830	Continued From page 4 the seat is being used. Risk of fall and serious injury may result if brakes are NOT locked while the user is sitting on the seat." Review of facility policy for Walker, Ambulating With, dated 2008, made no mention of using a wheeled walkers with a seat as a transportation device. During interview on 12/11/14, at 10:20 a.m., director of nursing stated she expected staff not to use the seated wheeled walker for transport and not to transport the resident backwards. Staff should have used a wheelchair when R12 was tired ambulating and not the wheeled walker for transportation which was not safe for R12. PERSONAL ALARM: R30 had diagnosis that included dementia, psychosis, anxiety and depression according to facility face sheet. R30's quarterly Minimum Data Set (MDS), dated 10/17/14, identified cognitively impairment, required extensive assist of two staff for bed mobility and transfers, and had two falls since last assessment with no injury. The facility quarterly safety risk assessment dated 10/17/14, identified R30 was at high risk for falls. The facility functional and balance assessment dated 10/17/14, identified R30 had poor balance, and was not steady to stand, walk, transfer, or toilet. During observations on 12/10/14, at 8:40 a.m., R30 sat in a wheelchair in the dining room feeding self breakfast. At that time, activity aide-A (AA-A) sat down to assist R30 with	2 830		

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2 830	Continued From page 5	2 830		

breakfast. R30 had a personal alarm box in small cloth pouch clipped to the back of wheelchair, with the alarm cord was clipped to the back of wheelchair. The personal alarm cord was not connected to R30. During interview at that time, AA-A stated she not aware of what the personal alarm box was for R30.

During interview on 12/10/14, at 8:44 a.m., registered nurse-B (RN-B) confirmed the wheelchair personal alarm was not connected to R30 and RN-B connected the personal alarm cord to the back of R30's shirt.

R30's care plan dated 10/20/14, identified R30 was at high risk for falls related to being unaware of safety needs, confusion, psychoactive medications, wandering, gait/balance problems, and incontinence. The goal was that R30 would not sustain serious injury through the review date. The interventions for this problem were to keep the environment safe with bilateral fall mats on the floor, anti-rollback device on wheelchair and personal alarm on R30's wheelchair.

Document review of resident incident reports from 7/25/14 to 11/29/14, a period of six months, revealed R30 had 5 falls with no injury. Review of the most recent fall which occurred on 11/29/14, at 6:45 p.m., indicated R30 attempted a self- transfer out of recliner and fell. The incident report identified R30's personal alarm was not in place.

During interview on 12/11/14, at 11:30 a.m., the director of nursing identified R30 had a history of falls and was a high falls risk. She stated R30 had a fall on 11/29/14, and the personal alarm was not connected to R30 when the fall occurred. She verified the alarms was used as an

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2 830	Continued From page 6 intervention for R30's falls, and expected staff to connect and use the personal alarm while R30 was in a wheelchair. SUGGESTED METHOD OF CORRECTION: The administrator could monitor and educate all staff to ensure they were aware of potential accident hazards, and use equipment per manufacture recommendations and implement fall intervention. The administrator or designee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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21426	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 new hired employees (E-M, E-O) received the second step of the tuberculin skin tests (TST). Findings include: Review of the employee health records identified E-O had hire date of 9/24/14. E-O received first step tuberculin skin test on 9/24/14, which was read on 9/27/14, as 0 millimeters. There was no evidence that a second step TST was administered. Review of employee health records identified E-M was hired on 8/6/14. The E-M received first step tuberculin skin test on 8/6/14, which was read on 8/8/14, as 0 millimeters. The second step tuberculin skin test was administered on 12/8/14, first day of the survey. Document review of facility tuberculosis screening-employees policy dated 2010, revealed page 6.31, " It is the policy of this facility that all healthcare workers be tested for tuberculosis upon hire and yearly thereafter, unless contraindicated. Initial testing will be a two-step procedure with the first dose given prior to beginning work and the second " booster " dose given 7-21 days after the first, if the first dose is negative along with an employee risk screening tool. " During interview on 12/10/14, at 1:00 p.m., director of nursing verified E-M and E-O lacked second step tuberculin skin tests. Director of nursing stated the facility policy was to administer	21426		

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21426	Continued From page 8 first step tuberculin skin tests and read the results before new hired employees could start work. The director of nursing stated she expected the second step skin test be administered within two weeks of the first test. Director of nursing verified she was responsible for the tuberculosis infection control program. SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure new hired employees received two step tuberculin skin tests timely. The director of nursing could inservice new hired employees regarding importance of two step tuberculin skin tests and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		