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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: S2Z5

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 **01/25/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 01/25/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/06/2017 (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
Posted 04/06/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/23/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245261
March 29, 2017

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

Dear Ms. Sandmann:

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

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

Effective January 23, 2017 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 28, 2017

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

RE: Project Number S5261027

Dear Ms. Sandmann:

On December 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 15, 2016. 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 January 25, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 25, 2017 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 December 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 15, 2016, effective January 23, 2017 and therefore remedies outlined in our letter to you dated December 29, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245261 Y1	A. Building B. Wing Y2	1/25/2017 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0170	Correction	ID Prefix	F0226	Correction	ID Prefix	F0257	Correction
Reg. #	483.10(g)(8)(i)(9)(i)-(iii)(h)(2)	Completed	Reg. #	483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed	Reg. #	483.10(i)(6)	Completed
LSC		01/23/2017	LSC		01/23/2017	LSC		01/23/2017
ID Prefix	F0329	Correction	ID Prefix	F0334	Correction	ID Prefix	F0431	Correction
Reg. #	483.45(d)(e)(1)-(2)	Completed	Reg. #	483.80(d)(1)(2)	Completed	Reg. #	483.45(b)(2)(3)(g)(h)	Completed
LSC		01/23/2017	LSC		01/23/2017	LSC		01/23/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 03/28/2017	SIGNATURE OF SURVEYOR 10562	DATE 01/25/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/15/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245261	A. Building 01 - MAIN BUILDING 01 B. Wing	1/25/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 01/23/2017	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/15/2016	☐ 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: S2Z5

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 **12/15/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 01/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/23/2017 (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
(L33)

Posted 01/23/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 29, 2016

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

RE: Project Number S5261027

Dear Ms. Sandmann:

On December 15, 2016, 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic 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 A Survey Team
Licensing & Certification
Health Regulation Division
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 January 24, 2017, 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 January 24, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 15, 2017 (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 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	12/15/2016

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 170 SS=C	483.10(g)(8)(i)(9)(i)-(iii)(h)(2) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL (g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law.	F 170		1/23/17

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

Electronically Signed | 01/09/2017

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 _____	12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 170	Continued From page 1 (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure delivery of personal mail to residents on Saturdays. This deficient practice had the potential to affect all 28 residents in the facility. Findings include: During interview on 12/14/16, at 1:53 p.m. residents (R)-25 and R-27 both stated they were not sure if the mail was delivered on Saturday's. During interview on 12/14/16, at 1:56 p.m. social service designee (SSD) stated the activity's person delivers the greeting cards, post cards and newspapers on Saturday's but the business mail is put on the SSD's desk for the SSD to deliver on Mondays. SSD also stated that residents who are their own representative will receive their business mail on Monday's when the SSD comes into the office. During interview on 12/14/6, at 2:01 p.m. the administrator stated mail is delivered Monday through Saturday. The administrator stated whoever is sorting the mail determines what business mail is and what personal mail is. The administrator stated under residents' rights all	F 170	F Tag 170 Right to send and receive mail && It is the policy of Wood Dale Home that a resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (1) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) at the resident□s expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to	

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F 170	Continued From page 2 mail should be delivered to all residents. The facility policy Mail dated 9/12, indicated mail would be delivered to residents unopened unless otherwise indicated by the attending physician and documented in the resident's medical record. It also indicated mail would be delivered to the resident within twenty four hours of delivery on premises or to the facility's post office box (including Saturday deliveries).	F 170	the facility for the resident, including those delivered through a means other than a postal service. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For Resident R25 and R27, and all other residents, mail will be delivered on Saturdays as well as other USPS postal days, unopened. 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, Social Service Director has retrained the activity staff that all mail addressed to the residents will be delivered, unopened, on any USPS postal days, including Saturdays. 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 Quality of Life Mail has been reviewed and revised by Social Service Director and Administrator. Staff members will be trained as it relates to their respective roles and responsibilities for protection of resident right to personal privacy and confidentiality by 1/20/17. How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for	

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F 170	Continued From page 3	F 170	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. Monitoring of mail delivery audits will be completed weekly for four weeks, and randomly thereafter for three months to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations. Who is responsible for this plan of correction? The Social Service Director will be responsible for compliance. Date of Correction: January 23, 2017	
F 226 SS=C	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to	F 226		1/23/17

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F 226	Continued From page 4 the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures related to prohibiting nursing home staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident. The failure to develop such policies/procedures had the potential to affect all 28 residents residing in the facility. Findings include: The facility's Abuse Prohibition Policy dated 8/12, defined mental abuse as: "this includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation." The policy did not address prohibition of staff utilizing photographs and audio/video recordings in a way that could demean or humiliate residents. During interview with the director of nursing on 12/12/16, at 2:55 p.m. during the entrance conference, the policy prohibiting staff utilization	F 226	F Tag 226 Staff Treatment of Residents It is the policy Wood Dale Home to develop and implement policies and procedures regarding screening and training employees to prevent, identify, and report abuse, neglect and mistreatment misappropriation of property..... What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no residents directly affected by the deficient practice. Corrective action will be that the policy Abuse Prohibition will be reviewed and revised to include "prohibition of utilization of photographs and audio/video material in a manner that would demean or humiliate a resident, regardless of resident consent" will be prohibited. The employee hand book has also been	

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F 226	Continued From page 5 of photographs and audio/video recordings in a way that could demean or humiliate residents by staff members, was requested. A policy Videotaping, Photographing and Other Imaging of Residents dated 9/06, was provided. The policy indicated that "Residents will be protected from invasion of privacy that might occur from the use of resident photographs, videotapes, digital images , and other visual recorders during resident care or other facility activities without the written consent of the resident." However, the policy did not address prohibition of utilization of photographs and audio/video material in a manner that would demean or humiliate a resident, regardless of resident consent. An Employee Handbook dated 10/16, directed to "Refraining from social media while on work time or on equipment we provide, unless it is work related as authorized by your department supervisor. The taking of photographs by any means at any Employer's facilities is prohibited without express advanced permission of a department supervisor, the administrator or the owner. This is to protect the privacy rights of our residents, our residents's family members and all employees." The employee handbook did not address the use of photographs or recordings in any manner that would demean or humiliate a resident. During interview on 12/14/16, at 1:28 p.m. the administrator stated she taught staff that use of cell phones and taking photographs of residents is prohibited per the employee handbook. The administrator further stated that she was aware of the requirement to develop such specific policies;	F 226	updated to include use of photographs or recordings in any manner that would demean or humiliate a resident are prohibited. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action to be taken? There were no residents directly affected by the deficient practice. 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 Abuse Prohibition has been reviewed and revised. The QA/QI Committee will review the policy to ensure all components are present. The employee hand book that was reviewed and updated as well to include the use of photographs or recordings in any manner that would demean or humiliate a resident is prohibited will also be reviewed by the QA/QI Committee to ensure all components are present. Staff members will be trained on 1/12/17. How does the facility plan to monitor its performance to made sure that solutions are sustained? The policy on Abuse Prohibition and the employee hand book revisions will be reviewed at next QA/QI meeting. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for	

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F 226	Continued From page 6 however, did not have a policy related to the new requirements. The administrator stated she was awaiting policy updates from "Med Pass" a company that provides policies, and was expected to receive them later this month.	F 226	compliance. Date of Correction: 1/23/17	
F 257 SS=D	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comfortable environment for 1 of 2 residents (R29) who complained of cold temperatures. Findings include: During interview in R29's room on 12/14/16, at 11:36 a.m. R29 stated "My feet are cold." R29 also stated," They tell me the room temp is 75 degrees, but my room feels cool, its always cold in here. I have to keep the door shut, cold air comes in from the hallway." During additional interview on 12/15/2016, at 9:15 a.m. R29 stated it still feels cold in her room and that she had to have three quilts on her lap to keep warm. During the environmental tour on 12/15/16, at 9:16 a.m. with maintenance director(M)-A , there was a large, approximately 1 inch, gap on bottom of exit door of the 200 wing. On the other side of the door was an entryway to the outside exterior	F 257	F Tag 257 Room Temperatures &. It is the policy of Wood Dale Home to operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in resident areas will be maintained according to items B to C: B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by Items B are allowed if the variations are based on documented resident preferences. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For Resident R29, she was asked if she wanted to move on 12/14/16 to a different room -- the outside temperature was -16. R29 at first said	1/23/17

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F 257	Continued From page 7 door. There was cold draft coming from under the entry way door. During interview on 12/15/2016, at 9:20 a.m. M-A stated the large gap under the 200 wing exit door had been there for years. M-A also verified the hallways are drafty and cool and that she could feel the cold air coming in from under the door. During interview on 12/15/2016, at 10:52 a.m. the administrator stated she was aware of the gap on the bottom of the end door on 200 wing. The administrator stated she would have M-A install a door sweep on the door. An undated form, Monthly Maintenance Inspection Checklist Resident Rooms included a column to check resident room heat /units and entrance doors. The checklist did not include an area to check room temperatures.	F 257	no, then she was shown room choices. R29 chose to move to a new room, Room 205. That night R29 complained to nursing staff that it was too hot and dry. On 12/15/16 R 29 stated that room was hot and dry. A humidifier was put in resident room on 12/16/16 for the dryness and heat. On 12/17/16 R 29 shared again her room was too warm. R29, even though she stated new room was too hot, had her legs wrapped in 3 or more blankets. Temperature of room heat will be taken every day for the room of R29. Temperatures of area heating units are taken daily and in resident rooms of other residents that share they are cold. Also a draft prevention device, a door sweep, was installed in the gap on the bottom of exit door of the 200 wing on 12/15/16. 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, checking of resident room temperatures will be added to the environmental checklist form and rounds made by the environmental staff for the adjustment of room temperatures and prevention of cold drafts, for the comfort of the resident. Temperatures will be maintained above 71 degrees during the heating season. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not	

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F 257	Continued From page 8	F 257	recur? The Monthly Maintenance Inspection Checklist Resident Room has been reviewed and revised by the Environmental Director on 1/3/17 to include checking of resident room temperatures in resident rooms on an intermittent schedule. Environmental staff will be trained as it relates to their respective roles and responsibilities before 1/20/17. 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 monitoring of resident room temperatures will be completed by Environmental Director weekly for four weeks, randomly for two 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 Environmental Director will be responsible for compliance. Date of Correction: 1/23/17.	
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when	F 329		1/23/17

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F 329	Continued From page 9 used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to initiate a taper, or provide justification for continued use, of antidepressant medications for 1 of 5 residents (R24) reviewed for unnecessary medications. Findings include: R24's quarterly Minimum Data Set (MDS) dated 10/19/16, indicated R24 had severe cognitive impairment and mild depression. The MDS included diagnoses of dementia, anxiety and depression and indicated R22 was receiving an antidepressant. R24's Order Summary Report signed by the physician on 12/9/16, directed staff to administer Zoloft (medication used to treat depression) 200 milligrams (mg) by mouth daily for depressive disorder. The orders indicated R24 had been	F 329	F TAge329 Unnecessary Drugs It is the policy of Wood Dale Home that each resident's drug regimen is free from unnecessary drugs. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? For resident R24 a fax was sent to her primary MD regarding the previously requested reduction in her Zoloft and family decline along with the reasons why the family felt it would be a bad decision. Primary MD reviewed the information and noted that he was in agreement with the reasons and decision to keep the Zoloft dose at current dose without a reduction at this time. How will you identify other residents	

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F 329	Continued From page 10 receiving the same dose of Zoloft since 6/2/15. During observation on 12/14/16, at 8:32 a.m. R24 was smiling and conversing with staff during morning cares. R24's pharmacy consult recommendation dated 5/12/16, suggested a decrease in Zoloft from 200 mg daily to 150 mg's daily. The physician agreed with this recommendation and authorized the change in dose. R24's progress note dated 5/17/16, at 7:58 a.m. indicated the facility received an order to decrease Zoloft to 150 mg a day. A message was left for R22's daughter to discuss. R24's progress note dated 5/17/16, at 9:15 a.m. indicated R24's daughter did not want the reduction in Zoloft as R22's Ativan (medication for anxiety) was just increased. R24's medical record lack any justification for current and continued use of Zoloft 200 mg's a day. During interview on 12/15/16, at 10:07 a.m. registered nurse (RN)-B stated that on 6/2/15, R24's Zoloft was increased from 100 mg's daily to 200 mg's daily. RN-B stated the pharmacist recommended a dose reduction for Zoloft in May of 2016 and the physician had ordered the reduction in dose. RN-B further stated the family refused the dose reduction, and that the physician did not provide a justification for continued use of the Zoloft at 200 mg daily. During interview on 12/15/16, at 10:14 a.m. the director of nursing stated that if a family disagrees	F 329	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 facility will review other residents who are currently taking a psychoactive medication to see that a gradual dose reduction, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs has been completed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility will review and revise policy for drug reduction to include residents who use psychoactive medication drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Licensed staff will be trained by 1/20/17 on reviewed policy. How the facility plans to monitor its performance to make sure that solutions are sustained? Audits will be completed monthly for the next three months, facility will utilize the MDS and Care Conference quarterly schedule to ensure continued compliance. 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.	

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F 329	Continued From page 11 with the pharmacy recommendation, the physician should be contacted with why the family does not feel a dosage change for the medication use is warranted, and request that the physician provide a justification for continued use should be made. An undated facility policy Drug Reduction, did not address tapering of antidepressant medications.	F 329	Date of Correction: 1/23/2017	
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 334		1/23/17

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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 334	Continued From page 12 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 334		

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 _____	12/15/2016

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WOOD DALE HOME INC	600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283

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F 334	Continued From page 13 Based on interview and document review the facilty failed to implement the Center for Disease Control (CDC) guidelines for pneumococcal conjugate vaccine (PCV13) for 3 of 5 residents (R1,R8,R45) whose vaccination histories were reviewed. Findings include: CDC identified adults ages 65 and older who have not previously had PCV13 and who have received at least one previous dose of PPSV23 (pneumococcal polysaccharide) should receive a dose of PCV13. The recommendations indicated a dose of PCV13 should be given at least one year after receipt of the most recent PPSV23 dose. R1's immunization history record indicated a pneumovax vaccine dose was given 1/2011. The dose on 1/2011 did not specify whether it was PPSV23 or PCV13. R8's immunization history record indicated a pneumovax vaccine dose was given 4/2011. The dose on 4/2011 did not specify whether it was PPSV23 or PCV13. R45's immunization history record failed to indicate whether any pneumovax vaccine was offered. During interview on 12/14/2016, at 2:45 p.m. the director of nursing (DON) stated she had gone through each of the resident's immunization records and no confirmed no residents had received the PCV13 vaccine. The DON acknowledged some residents had received the PPSV23 vaccine. The DON also stated the	F 334	F Tag 334 Influenza and pneumococcal immunizations It is the policy of Wood Dale Home to develop policies and procedures to ensure that before offering the influenza and pneumococcal immunizations that each residents representative receives education regarding the benefits and potential side effects of the immunization. Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period. The resident or representative has the opportunity to refuse immunizations, the resident medical record includes documentation at minimum that resident or representative was provided education regarding the benefits and potential side effects of influenza, that the resident either received the immunizations or did not due to medical contraindications or refusal. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? For residents R1, R8, and R45 they or their representative was offered the recommended pneumococcal conjugated vaccine (PCV13) or the pneumococcal polysaccharide (PPSV23) according to Center for Disease Control (CDC) guidelines along with education regarding the benefits and potential side effects of the immunization. The immunization will be administered to those who consented to the immunization.	

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F 334	Continued From page 14 pharmacist had talked about the PCV13 vaccine guidelines and stated the facility was working on drafting a pneumococcal consent with the vaccine language from the CDC guidelines. The facility's policy, Resident Pneumococcal Vaccine dated 3/11/10, identified during the admission process a resident is offered a pneumococcal vaccine unless medically contraindicated or the resident has already been immunized in the last 5 years. The facility policy did not include current CDC guidelines related to PCV13 and PPSV23 pneumococcal vaccines.	F 334	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 all residents a letter was sent out to all residents and/or representatives that the facility was offering the recommended pneumococcal conjugated vaccine (PCV13) or the pneumococcal polysaccharide (PPSV23) according to Center of Disease Control (CDC) guidelines along with education regarding the benefits and potential side effects of the immunization. The immunization will be administered to those who consented to the immunization. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility will review and revise the pneumococcal immunization policy to include the current CDC guidelines related to PCV13 and PPSV23 pneumococcal vaccines. The facility will also update there admission documentation to include the current CDC guidelines related to PCV13 and PPSV23 with the benefits and potential side effects so that residents and/or representatives can make an informed decision about the vaccination. Licensed staff will be trained by 1/20/17. 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	

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F 334	Continued From page 15	F 334	evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Audits will be completed weekly for four weeks then monthly for three months with the review of findings at QA/QI Committee for further recommendations Who is responsible for this plan of correction? The Director of nursing or designee will be responsible for compliance. Date of Correction: 1/23/17 The charge nurse will verify the insulin pens are individually labeled upon receiving from pharmacy and if not immediately request labels to be delivered to the facility.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		1/23/17

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F 431	Continued From page 16 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	F Tag 431	

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F 431	Continued From page 17 review, the facility failed to ensure insulin (medication to control blood sugar) was labeled appropriately prior to administration for 2 of 2 residents (R38, R25) reviewed who used insulin. Findings include: R38's quarterly Minimum Data Set (MDS) assessment dated 11/18/16, identified R38 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels which may require insulin). R38's physican orders dated 12/13/16, identified R38 received Humalog (type of insulin medication used for diabetes) 10 units subcutaneously three times a day. R25's quarterly Minimum Data Set (MDS) dated 9/22/16, identified R25 had type two diabetes mellitus. Review of R25's physican orders dated 12/13/16, identified R25 recieved Levemir (type of insulin medication used for diabetes) 56 units in the morning and 63 units in the evening. During observation of the medication cart 12/13/16, at 9:45 a.m. R38's Humalog and R25's Levemir pens were located in the medication cart inside their glucometer cases. R38's Humalog pen was not labeled with R38's name nor was there an expiration date located on the insulin pen which had been filled by the pharmacy on 11/8/16. R25's Levemir pen was not labeled with R25's name. During interview on 12/13/16, at 9:46 a.m. registered nurse (RN)-A stated all opened insulin	F 431	Labeling of Drugs and Biologicals What correction action will be accomplished for those residents found to have been affected by the deficient practice? For resident R38 and R25 the unlabeled insulin pens were immediately discarded and new pens were opened and labeled with resident initials, date opened and new expiration date. 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 facility reviewed all other residents' medications that require labeling and documented date opened for compliance. The facility sent written notice to both local pharmacies that dispense insulin pens to open each box and label each individual pen. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The charge nurse will verify the insulin pens are individually labeled upon receiving from pharmacy and if not immediately request labels to be delivered to the facility. The policy and procedure for medication labeling was reviewed and revised. A review of this policy will be reviewed by the Medical Director of ensure current standards of practice are in place. A licensed nursing meeting will be held by 1/20/17 to review revised policy and procedure.	

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F 431	Continued From page 18 pens should be labeled with the resident's name and should include an expiration date. RN-A stated R38 and R25 did not have any other insulin pens located in the medication cart. When interviewed on 12/13/16, at 3:28 p.m. RN-B also stated all opened insulin should be labeled with the resident's name and expiration date. RN-B stated the facility had issues with unlabeled/undated insulin pens in the past. Further, RN-B stated insulin pens expire after 28 days . During interview on 12/13/16, at 3:34 p.m. the director of nursing stated all new insulin pens should be labeled with the resident's name and the date when opened. Further, the DON stated it could become a "safety issue" as the facility had several residents on insulin. A facility policy on labeling and storing of medications was requested, but was not provided.	F 431	How the facility plans to monitor its performance to make sure that solutions are sustained? Pharmacy audits will be completed weekly for four weeks and monthly for three months to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 1/23/2017	

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	245261	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/15/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 15, 2016. At the time of this survey, Wood Dale Home Incorporated was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/03/2017

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.

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Wood Dale Home Incorporated is a one-story building with no basement. It was constructed in 1976, is fully fire sprinkler protected and was determined to be of Type II(222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has single-station, battery operated smoke alarms in all Resident Rooms. The facility has a licensed capacity of 40 beds and had a census of 29 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT met by evidenced by:	K 000		
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview,	K 918	K918 Electrical Systems - Essential	1/23/17

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K 918	Continued From page 3 the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 29 of 29 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE:	K 918	Electric System A oomplete written record of Generator maintenance and testing will be maintained and readily available. The transfer of time of how long it takes the emergency generator to assume power and the cool down time after the generator does the 30 minute load test will be recorded. Proposed Completion date: January 23, 2017 Environmental Director/Maintenance Director is responsible for correction and monitoring to prevent reoccurrence of this deficiency.	

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K 918	Continued From page 4 On facility tour between 11:00 AM and 2:00 PM on 12/15/2016, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test. The transfer time of how long it takes the emergency generator to assume power and the cool down time after the generator does the 30 minute load test is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
December 29, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5261027

Dear Ms. Sandmann:

The above facility was surveyed on December 12, 2016 through December 15, 2016 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 me.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
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Enclosure(s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00749	A. BUILDING: _____ B. WING _____	12/15/2016

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) 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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 12th - December 15th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 385	Continued From page 2	2 385		
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure delivery of personal mail to residents on Saturdays. This deficient practice had the potential to affect all 28 residents in the facility. Findings include: During interview on 12/14/16, at 1:53 p.m. residents (R)-25 and R-27 both stated they were not sure if the mail was delivered on Saturday's. During interview on 12/14/16, at 1:56 p.m. social service designee (SSD) stated the activity's person delivers the greeting cards, post cards and newspapers on Saturday's but the business mail is put on the SSD's desk for the SSD to deliver on Mondays. SSD also stated that residents who are their own representative will receive their business mail on Monday's when the SSD comes into the office. During interview on 12/14/6, at 2:01 p.m. the administrator stated mail is delivered Monday through Saturday. The administrator stated	2 385		

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2 385	Continued From page 3 whoever is sorting the mail determines what business mail is and what personal mail is. The administrator stated under residents' rights all mail should be delivered to all residents. The facility policy Mail dated 9/12, indicated mail would be delivered to residents unopened unless otherwise indicated by the attending physician and documented in the resident's medical record. It also indicated mail would be delivered to the resident within twenty four hours of delivery on premises or to the facility's post office box (including Saturday deliveries). SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and update policies regarding resident's mail and provide education to staff regarding any changes to ensure all residents receive their mail as delivered, including on weekends. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 385		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply	21535		

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21535	Continued From page 4	21535		

with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to initiate a taper, or provide justification for continued use, of antidepressant medications for 1 of 5 residents (R24) reviewed for unnecessary medications.

Findings include:

R24's quarterly Minimum Data Set (MDS) dated 10/19/16, indicated R24 had severe cognitive impairment and mild depression. The MDS included diagnoses of dementia, anxiety and depression and indicated R22 was receiving an antidepressant.

R24's Order Summary Report signed by the physician on 12/9/16, directed staff to administer Zoloft (medication used to treat depression) 200 milligrams (mg) by mouth daily for depressive disorder. The orders indicated R24 had been receiving the same dose of Zoloft since 6/2/15.

During observation on 12/14/16, at 8:32 a.m. R24 was smiling and conversing with staff during morning cares.

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21535	Continued From page 5 R24's pharmacy consult recommendation dated 5/12/16, suggested a decrease in Zoloft from 200 mg daily to 150 mg's daily. The physician agreed with this recommendation and authorized the change in dose. R24's progress note dated 5/17/16, at 7:58 a.m. indicated the facility received an order to decrease Zoloft to 150 mg a day. A message was left for R22's daughter to discuss. R24's progress note dated 5/17/16, at 9:15 a.m. indicated R24's daughter did not want the reduction in Zoloft as R22's Ativan (medication for anxiety) was just increased. R24's medical record lack any justification for current and continued use of Zoloft 200 mg's a day. During interview on 12/15/16, at 10:07 a.m. registered nurse (RN)-B stated that on 6/2/15, R24's Zoloft was increased from 100 mg's daily to 200 mg's daily. RN-B stated the pharmacist recommended a dose reduction for Zoloft in May of 2016 and the physician had ordered the reduction in dose. RN-B further stated the family refused the dose reduction, and that the physician did not provide a justification for continued use of the Zoloft at 200 mg daily. During interview on 12/15/16, at 10:14 a.m. the director of nursing stated that if a family disagrees with the pharmacy recommendation, the physician should be contacted with why the family does not feel a dosage change for the medication use is warranted, and request that the physician provide a justification for continued use should be made.	21535		

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21535	Continued From page 6 An undated facility policy Drug Reduction, did not address tapering of antidepressant medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents' drug regimes are reviewed for gradual dose reduction and tapering of medication. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin (medication to control blood sugar) was labeled appropriately prior to administration for 2 of 2 residents (R38, R25) reviewed who used insulin. Findings include: R38's quarterly Minimum Data Set (MDS) assessment dated 11/18/16, identified R38 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels which may require insulin).	21620		

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21620	Continued From page 7 R38's physican orders dated 12/13/16, identified R38 received Humalog (type of insulin medication used for diabetes) 10 units subcutaneously three times a day. R25's quarterly Minimum Data Set (MDS) dated 9/22/16, identified R25 had type two diabetes mellitus. Review of R25's physican orders dated 12/13/16, identified R25 recieved Levemir (type of insulin medication used for diabetes) 56 units in the morning and 63 units in the evening. During observation of the medication cart 12/13/16, at 9:45 a.m. R38's Humalog and R25's Levemir pens were located in the medication cart inside their glucometer cases. R38's Humalog pen was not labeled with R38's name nor was there an expiration date located on the insulin pen which had been filled by the pharmacy on 11/8/16. R25's Levemir pen was not labeled with R25's name. During interview on 12/13/16, at 9:46 a.m. registered nurse (RN)-A stated all opened insulin pens should be labeled with the resident's name and should include an expiration date. RN-A stated R38 and R25 did not have any other insulin pens located in the medication cart. When interviewed on 12/13/16, at 3:28 p.m. RN-B also stated all opened insulin should be labeled with the resident's name and expiration date. RN-B stated the facility had issues with unlabeled/undated insulin pens in the past. Further, RN-B stated insulin pens expire after 28 days .	21620		

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21620	Continued From page 8 During interview on 12/13/16, at 3:34 p.m. the director of nursing stated all new insulin pens should be labeled with the resident's name and the date when opened. Further, the DON stated it could become a "safety issue" as the facility had several residents on insulin. A facility policy on labeling and storing of medications was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage and labeling of medications. Nursing staff could be educated as necessary, on the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times.	21705		

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21705	Continued From page 9 B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comfortable environment for 1 of 2 residents (R29) who complained of cold temperatures. Findings include: During interview in R29's room on 12/14/16, at 11:36 a.m. R29 stated "My feet are cold." R29 also stated," They tell me the room temp is 75 degrees, but my room feels cool, its always cold in here. I have to keep the door shut, cold air comes in from the hallway." During additional interview on 12/15/2016, at 9:15 a.m. R29 stated it still feels cold in her room and that she had to have three quilts on her lap to keep warm. During the environmental tour on 12/15/16, at 9:16 a.m. with maintenance director(M)-A , there was a large, approximately 1 inch, gap on bottom of exit door of the 200 wing. On the other side of the door was an entryway to the outside exterior door. There was cold draft coming from under the entry way door. During interview on 12/15/2016, at 9:20 a.m. M-A stated the large gap under the 200 wing exit door had been there for years. M-A also verified the hallways are drafty and cool and that she could	21705		

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21705	Continued From page 10 feel the cold air coming in from under the door. During interview on 12/15/2016, at 10:52 a.m. the administrator stated she was aware of the gap on the bottom of the end door on 200 wing. The administrator stated she would have M-A install a door sweep on the door. An undated form, Monthly Maintenance Inspection Checklist Resident Rooms included a column to check resident room heat /units and entrance doors. The checklist did not include an area to check room temperatures. SUGGESTED METHOD OF CORRECTION: The environmental services director (ED), could conduct audits to ensure room temperatures are comfortable for residents. TIME PERIOD FOR CORRECTION: Twenty - one (21) days.	21705		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services	22000		

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22000	Continued From page 11 providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures related to prohibiting nursing home staff from	22000		

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22000	Continued From page 12 taking or using photographs or recordings in any manner that would demean or humiliate a resident. The failure to develop such policies/procedures had the potential to affect all 28 residents residing in the facility. Findings include: The facility's Abuse Prohibition Policy dated 8/12, defined mental abuse as: "this includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation." The policy did not address prohibition of staff utilizing photographs and audio/video recordings in a way that could demean or humiliate residents. During interview with the director of nursing on 12/12/16, at 2:55 p.m. during the entrance conference, the policy prohibiting staff utilization of photographs and audio/video recordings in a way that could demean or humiliate residents by staff members, was requested. A policy Videotaping, Photographing and Other Imaging of Residents dated 9/06, was provided. The policy indicated that "Residents will be protected from invasion of privacy that might occur from the use of resident photographs, videotapes, digital images , and other visual recorders during resident care or other facility activities without the written consent of the resident." However, the policy did not address prohibition of utilization of photographs and audio/video material in a manner that would demean or humiliate a resident, regardless of resident consent. An Employee Handbook dated 10/16, directed to "Refraining from social media while on work time or on equipment we provide, unless it is work	22000		

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22000	Continued From page 13 related as authorized by your department supervisor. The taking of photographs by any means at any Employer's facilities is prohibited without express advanced permission of a department supervisor, the administrator or the owner. This is to protect the privacy rights of our residents, our residents's family members and all employees." The employee handbook did not address the use of photographs or recordings in any manner that would demean or humiliate a resident. During interview on 12/14/16, at 1:28 p.m. the administrator stated she taught staff that use of cell phones and taking photographs of residents is prohibited per the employee handbook. The administrator further stated that she was aware of the requirement to develop such specific policies; however, did not have a policy related to the new requirements. The administrator stated she was awaiting policy updates from "Med Pass" a company that provides policies, and was expected to receive them later this month. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure policies related to potential resident abuse were developed to include all forms of potential abuse. The administrator or diesignee could educate all staff on these policy and procedures. The administrator or designee could then monitor and audit to ensure staff adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	22000		

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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) 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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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 _____	12/15/2016

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 12th - December 15th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 385	Continued From page 2	2 385		
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure delivery of personal mail to residents on Saturdays. This deficient practice had the potential to affect all 28 residents in the facility. Findings include: During interview on 12/14/16, at 1:53 p.m. residents (R)-25 and R-27 both stated they were not sure if the mail was delivered on Saturday's. During interview on 12/14/16, at 1:56 p.m. social service designee (SSD) stated the activity's person delivers the greeting cards, post cards and newspapers on Saturday's but the business mail is put on the SSD's desk for the SSD to deliver on Mondays. SSD also stated that residents who are their own representative will receive their business mail on Monday's when the SSD comes into the office. During interview on 12/14/6, at 2:01 p.m. the administrator stated mail is delivered Monday through Saturday. The administrator stated	2 385	Corrected	1/3/17

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2 385	Continued From page 3 whoever is sorting the mail determines what business mail is and what personal mail is. The administrator stated under residents' rights all mail should be delivered to all residents. The facility policy Mail dated 9/12, indicated mail would be delivered to residents unopened unless otherwise indicated by the attending physician and documented in the resident's medical record. It also indicated mail would be delivered to the resident within twenty four hours of delivery on premises or to the facility's post office box (including Saturday deliveries). SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and update policies regarding resident's mail and provide education to staff regarding any changes to ensure all residents receive their mail as delivered, including on weekends. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 385		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply	21535		1/3/17

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21535	Continued From page 4 with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to initiate a taper, or provide justification for continued use, of antidepressant medications for 1 of 5 residents (R24) reviewed for unnecessary medications. Findings include: R24's quarterly Minimum Data Set (MDS) dated 10/19/16, indicated R24 had severe cognitive impairment and mild depression. The MDS included diagnoses of dementia, anxiety and depression and indicated R22 was receiving an antidepressant. R24's Order Summary Report signed by the physician on 12/9/16, directed staff to administer Zoloft (medication used to treat depression) 200 milligrams (mg) by mouth daily for depressive disorder. The orders indicated R24 had been receiving the same dose of Zoloft since 6/2/15. During observation on 12/14/16, at 8:32 a.m. R24 was smiling and conversing with staff during morning cares.	21535	Corrected	

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21535	Continued From page 5 R24's pharmacy consult recommendation dated 5/12/16, suggested a decrease in Zoloft from 200 mg daily to 150 mg's daily. The physician agreed with this recommendation and authorized the change in dose. R24's progress note dated 5/17/16, at 7:58 a.m. indicated the facility received an order to decrease Zoloft to 150 mg a day. A message was left for R22's daughter to discuss. R24's progress note dated 5/17/16, at 9:15 a.m. indicated R24's daughter did not want the reduction in Zoloft as R22's Ativan (medication for anxiety) was just increased. R24's medical record lack any justification for current and continued use of Zoloft 200 mg's a day. During interview on 12/15/16, at 10:07 a.m. registered nurse (RN)-B stated that on 6/2/15, R24's Zoloft was increased from 100 mg's daily to 200 mg's daily. RN-B stated the pharmacist recommended a dose reduction for Zoloft in May of 2016 and the physician had ordered the reduction in dose. RN-B further stated the family refused the dose reduction, and that the physician did not provide a justification for continued use of the Zoloft at 200 mg daily. During interview on 12/15/16, at 10:14 a.m. the director of nursing stated that if a family disagrees with the pharmacy recommendation, the physician should be contacted with why the family does not feel a dosage change for the medication use is warranted, and request that the physician provide a justification for continued use should be made.	21535		

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21535	Continued From page 6 An undated facility policy Drug Reduction, did not address tapering of antidepressant medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents' drug regimes are reviewed for gradual dose reduction and tapering of medication. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin (medication to control blood sugar) was labeled appropriately prior to administration for 2 of 2 residents (R38, R25) reviewed who used insulin. Findings include: R38's quarterly Minimum Data Set (MDS) assessment dated 11/18/16, identified R38 had type two diabetes mellitus (metabolic disease causing increase blood glucose levels which may require insulin).	21620	Corrected	1/3/17

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21620	Continued From page 7 R38's physican orders dated 12/13/16, identified R38 received Humalog (type of insulin medication used for diabetes) 10 units subcutaneously three times a day. R25's quarterly Minimum Data Set (MDS) dated 9/22/16, identified R25 had type two diabetes mellitus. Review of R25's physican orders dated 12/13/16, identified R25 recieved Levemir (type of insulin medication used for diabetes) 56 units in the morning and 63 units in the evening. During observation of the medication cart 12/13/16, at 9:45 a.m. R38's Humalog and R25's Levemir pens were located in the medication cart inside their glucometer cases. R38's Humalog pen was not labeled with R38's name nor was there an expiration date located on the insulin pen which had been filled by the pharmacy on 11/8/16. R25's Levemir pen was not labeled with R25's name. During interview on 12/13/16, at 9:46 a.m. registered nurse (RN)-A stated all opened insulin pens should be labeled with the resident's name and should include an expiration date. RN-A stated R38 and R25 did not have any other insulin pens located in the medication cart. When interviewed on 12/13/16, at 3:28 p.m. RN-B also stated all opened insulin should be labeled with the resident's name and expiration date. RN-B stated the facility had issues with unlabeled/undated insulin pens in the past. Further, RN-B stated insulin pens expire after 28 days .	21620		

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21620	Continued From page 8 During interview on 12/13/16, at 3:34 p.m. the director of nursing stated all new insulin pens should be labeled with the resident's name and the date when opened. Further, the DON stated it could become a "safety issue" as the facility had several residents on insulin. A facility policy on labeling and storing of medications was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage and labeling of medications. Nursing staff could be educated as necessary, on the importance of labeling medications properly. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times.	21705		1/3/17

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21705	Continued From page 9 B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comfortable environment for 1 of 2 residents (R29) who complained of cold temperatures. Findings include: During interview in R29's room on 12/14/16, at 11:36 a.m. R29 stated "My feet are cold." R29 also stated," They tell me the room temp is 75 degrees, but my room feels cool, its always cold in here. I have to keep the door shut, cold air comes in from the hallway." During additional interview on 12/15/2016, at 9:15 a.m. R29 stated it still feels cold in her room and that she had to have three quilts on her lap to keep warm. During the environmental tour on 12/15/16, at 9:16 a.m. with maintenance director(M)-A , there was a large, approximately 1 inch, gap on bottom of exit door of the 200 wing. On the other side of the door was an entryway to the outside exterior door. There was cold draft coming from under the entry way door. During interview on 12/15/2016, at 9:20 a.m. M-A stated the large gap under the 200 wing exit door had been there for years. M-A also verified the hallways are drafty and cool and that she could	21705	Corrected	

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21705	Continued From page 10 feel the cold air coming in from under the door. During interview on 12/15/2016, at 10:52 a.m. the administrator stated she was aware of the gap on the bottom of the end door on 200 wing. The administrator stated she would have M-A install a door sweep on the door. An undated form, Monthly Maintenance Inspection Checklist Resident Rooms included a column to check resident room heat /units and entrance doors. The checklist did not include an area to check room temperatures. SUGGESTED METHOD OF CORRECTION: The environmental services director (ED), could conduct audits to ensure room temperatures are comfortable for residents. TIME PERIOD FOR CORRECTION: Twenty - one (21) days.	21705		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services	22000		1/3/17

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22000	Continued From page 11 providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures related to prohibiting nursing home staff from	22000	Corrected	

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22000	Continued From page 12 taking or using photographs or recordings in any manner that would demean or humiliate a resident. The failure to develop such policies/procedures had the potential to affect all 28 residents residing in the facility. Findings include: The facility's Abuse Prohibition Policy dated 8/12, defined mental abuse as: "this includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation." The policy did not address prohibition of staff utilizing photographs and audio/video recordings in a way that could demean or humiliate residents. During interview with the director of nursing on 12/12/16, at 2:55 p.m. during the entrance conference, the policy prohibiting staff utilization of photographs and audio/video recordings in a way that could demean or humiliate residents by staff members, was requested. A policy Videotaping, Photographing and Other Imaging of Residents dated 9/06, was provided. The policy indicated that "Residents will be protected from invasion of privacy that might occur from the use of resident photographs, videotapes, digital images , and other visual recorders during resident care or other facility activities without the written consent of the resident." However, the policy did not address prohibition of utilization of photographs and audio/video material in a manner that would demean or humiliate a resident, regardless of resident consent. An Employee Handbook dated 10/16, directed to "Refraining from social media while on work time or on equipment we provide, unless it is work	22000		

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22000	Continued From page 13 related as authorized by your department supervisor. The taking of photographs by any means at any Employer's facilities is prohibited without express advanced permission of a department supervisor, the administrator or the owner. This is to protect the privacy rights of our residents, our residents's family members and all employees." The employee handbook did not address the use of photographs or recordings in any manner that would demean or humiliate a resident. During interview on 12/14/16, at 1:28 p.m. the administrator stated she taught staff that use of cell phones and taking photographs of residents is prohibited per the employee handbook. The administrator further stated that she was aware of the requirement to develop such specific policies; however, did not have a policy related to the new requirements. The administrator stated she was awaiting policy updates from "Med Pass" a company that provides policies, and was expected to receive them later this month. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure policies related to potential resident abuse were developed to include all forms of potential abuse. The administrator or diesignee could educate all staff on these policy and procedures. The administrator or designee could then monitor and audit to ensure staff adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	22000		