CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: S2Z5

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Fa	cility ID: 00749
MEDICARE/MEDICAID PROVIDER (L1) 245261 2.STATE VENDOR OR MEDICAID NO. (L2) 484243000	NO.	3. NAME AND AD (L3) WOOD DAL (L4) 600 SUNRIS (L5) REDWOOD	E HOME INC	ГҮ	(L6) 56283	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	/NERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Com	9. Other plaint
6. DATE OF SURVEY 01/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING D	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	40 (L18) 40 (L17)	X A. In Complian Program Re Compliance1. A B. Not in Com	quirements		And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN) 5. Life Safety Code * Code: A*	6. Scope of Service 7. Medical Director	r
14. LTC CERTIFIED BED BREAKDOWI 18 SNF 18/19 SNF 40 (L37) (L38)	19 SNF (L39)	ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):				
Brenda Fischer, U	•		01/25/2017	(L19)	Kate JohnsTon, P	rogram Specialist	Date:04/06/2017 (L20)
19. DETERMINATION OF ELIGIBILIT _X	Y	20. COM	D BY HCFA RE 1PLIANCE WITH CHTS ACT:			ncial Solvency (HCFA-2572) of Interest Disclosure Stmt (HCFA-	1513)
22. ORIGINAL DATE OF PARTICIPATION 10/01/1983 (L24)	23. LTC AGREEMI BEGINNING I (L41)		24. LTC AGREEME ENDING DATE (L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimbursen	nent 06-Fail to Mee	RY t Health/Safety
25. LTC EXTENSION DATE: (L27)	A. Suspension of B. Rescind Susp	of Admissions:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider St 00-Active	tatus Change
28. TERMINATION DATE:	29. (L28)	. INTERMEDIARY/C	CARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	32. (L32)	DETERMINATION (01/23/2017	OF APPROVAL DAT	(L33)	Posted 04/06/2017 Co. DETERMINATION APPRO	OVAL	



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.

Wood Dale Home Inc March 29, 2017 Page 2

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



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.

Wood Dale Home, Inc. March 28, 2017 Page 2

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

ID Prefix

		POST	-CERT	IFICATIO	N REVI	SIT RE	EPORT			
PROVIDE	R / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION						DATE OF	REVISIT
	CATION NUMBER	A. Building B. Wing							1/25/201	17
245261	Y1	B. Willy			1			Y2	1/23/20	Y3
	FACILITY				1	,	Y, STATE, ZIF	CODE		
WOOD DALE HOME INC				600 SUNRIS						
REDWOOD FALLS, MN 56283										
program, corrected provision	ort is completed by a quali- to show those deficiencied and the date such correc- number and the identifica- try report form).	es previously repo ctive action was a	orted on the accomplishe	CMS-2567, Stater d. Each deficiency	ment of Defic should be for	iencies and ully identifie	Plan of Cor d using eithe	rection, that have ler the regulation or	LSC	
ITE	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0170	Correction	ID Prefix	F0226	Co	rrection	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)	Co	mpleted	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	Co	rrection	ID Prefix	F0431		Correction
Reg.#	483.45(d)(e)(1)-(2)	Completed	Reg. #	483.80(d)(1)(2)	Co	mpleted	Reg. #	483.45(b)(2)(3)(g)(h	า)	Completed
LSC		01/23/2017	LSC		01/	23/2017	LSC			01/23/2017

ID Prefix

Correction

Correction

ID Prefix

Correction

POST-CERTIFICATION REVISIT REPORT

	1 001-0EKTH TOATTON KEYTOTT KET OKT								
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245261	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 1/25/2017 Y3						
NAME OF FACILITY WOOD DALE HOME INC	•	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283							
program, to show those deficienci corrected and the date such corre	es previously reported on the CMS-2567, Stat ctive action was accomplished. Each deficien	d and/or Clinical Laboratory Improvement Amendments ement of Deficiencies and Plan of Correction, that have cy should be fully identified using either the regulation of S-2567 (prefix codes shown to the left of each requirement)	r LSC						

the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	01/23/2017	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	
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 INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
	REVIEWED BY INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/15/2016			ANY UNCORRECTED DEFICIENCIE: TED DEFICIENCIES (CMS-2567) SEN		YES NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: S2Z5

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY AG	ENCY	F	acility ID: 00749
1. MEDICARE/MEDICAID PROVID (L1) 245261 2.STATE VENDOR OR MEDICAID I (L2) 484243000		3. NAME AND ADD (L3) WOOD DAL (L4) 600 SUNRISI (L5) REDWOOD	E HOME INC E BOULEVARD	ГҮ	(L6)	56283	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other mplaint
6. DATE OF SURVEY 1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJG 2 AOA 3 Od		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 S 40	40 (L18) 40 (L17) OWN NF 19 SNF	X B. Not in Com Requirements a	nce With quirements Based On: Acceptable POC pliance with Program and/or Applied Waiv		2. Tech 3. 24 H 4. 7-Da	nnical Personnel four RN ay RN (Rural SNF) Safety Code B* MEETS	Following Requirements:	cor
(L37) (L38) 16. STATE SURVEY AGENCY REM		(L42) SHOW LTC CANCELL	(L43) ATION DATE):					
17. SURVEYOR SIGNATURE Jennifer Ba	hr, HFE NE II	Date :	01/09/2017	(L19)		vey agency app	PROVAL Ogram Specialis	Date:
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBI 1. Facility is Eligible t 2. Facility is not Eligi	o Participate		IPLIANCE WITH C	IVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/01/1983 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00		eet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Involut 04-Other Reason f		OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539		. DETERMINATION (OF APPROVAL DAT	_	Posted 01/23	3/2017 Co.		
	(L32)			(L33)	DETERMINA	ATION APPROV	VAL	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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

PRINTED: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245261	B. WING			12/	15/2016
	PROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F C	000			
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 170 SS=C	on-site revisit of you validate that substa regulations has bee your verification. 483.10(g)(8)(i)(9)(i)	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with -(iii)(h)(2) RIGHT TO RECEIVE UNOPENED MAIL	F 1	170			1/23/17
	receive mail, and to other materials deli- resident through a r service, including th	•					
	(i) Privacy of such of with this section; ar	communications consistent ad					
		ons such as email and video and for internet research.					
	(i) If the access is a	vailable to the facility					
		expense, if any additional I by the facility to provide such ent.					
	(iii) Such use must law.	comply with State and Federal					
LABORATOR'	 Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

PRINTED: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245261	B. WING _		12/	15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIED TO THE APP	JLD BE	(X5) COMPLETION DATE
F 170	(h)(2) The facility method to personal privacy in his or her oral (the electronic communication of the personal privacy in his or her oral (the electronic communication of the personal and promptly other letters, packadelivered to the facility electronic through a service. This REQUIREME by: Based on interview facility failed to ensure idents on Saturch and the potential to facility. Findings include: During interview or residents (R)-25 ar not sure if the mail During interview or service designee (sperson delivers the and newspapers of mail is put on the Selver on Mondays residents who are receive their busines SSD comes into the During interview or administrator state through Saturday. Whoever is sorting business mail is an electronic communication of the service of the person delivers the same state of the perso	nust respect the residents right in including the right to privacy nat is, spoken), written, and incations, including the right to receive unopened mail and ages and other materials cility for the resident, including ough a means other than a inc	F 17	F Tag 170 Right to send and rece & It is the policy of Wood Dale Horresident has the right to send an mail, and to receive letters, pack other materials delivered to the the resident through a means of postal service, including the righ (1) Privacy of such communicat consistent with this section; and (g)(9) communications such as video communications and for ir research. (i) If the access is available to th (ii) at the resident sexpense, if additional expense is incurred by facility to provide such access to resident. (iii) Such use must comply with Federal law. (h)(2) The facility must respect residents right to personal privacincluding the right to privacy in horal (that is, spoken), written, an electronic communications, incluright to send and promptly receivunopened mail and other letters packages and other materials de	me that a d receive sages and facility for her than a t to: ions email and aternet e facility any y the the State and the cy, is or her d uding the ye	

Facility ID: 00749

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		245261	B. WING			12/15/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WOOD D	ALE HOME INC			600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 170	The facility policy M would be delivered otherwise indicated and documented in It also indicated maresident within twer	vered to all residents. fail dated 9/12, indicated mail to residents unopened unless by the attending physician the resident's medical record. We will would be delivered to the new four hours of delivery on facility's post office box	F1	the facility for the resident delivered through a means postal service. What corrective action(s) accomplished for those rehave been affected by the practice? For Resident R25 and R2 residents, mail will be delivered as well as othe days, unopened. How will you identify other having the potential to be same deficient practice ar corrective action will be ta residents who may be affer practice, Social Service Destroice, Social Service Destroice are the activity staffer addressed to the residents delivered, unopened, on a days, including Saturdays. What measures will be pure what systemic changes with ensure that the deficient percur? The policy on Qual Mail has been reviewed as Social Service Director and Staffer members will be train to their respective roles are responsibilities for protect right to personal privacy a confidentiality by 1/20/17. How the facility plans to me performance to make sure are sustained? Develop a	will be esidents found enonitor its established and into place in the control of	nd to ther stal the other s ostal or to s not oy ator. ates ent

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245261	B. WING _			12/·	15/2016
	PROVIDER OR SUPPLIER ALE HOME INC			60	REET ADDRESS, CITY, STATE, ZIP CODE O SUNRISE BOULEVARD EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 170 F 226 SS=C	DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre-	3.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC develop and implement procedures that: vent abuse, neglect, and	F 1		ensuring that correction is achieved sustained. This plan must be implemented, and the corrective ace evaluated for its effectiveness. The of correction is integrated into the cassurance system. Monitoring of redelivery audits will be completed we for four weeks, and randomly therefor three months to ensure continucompliance with results reported to QA/QI Committee for review and fur recommendations. Who is responsible for this plan of correction? The Social Service Dirwill be responsible for compliance. Date of Correction: January 23, 20	etion e plan quality nail eekly after led the urther	1/23/17
	resident property,	ents and misappropriation of sand procedures to allegations, and					
	(3) Include training §483.95,	as required at paragraph					
	483.95 (c) Abuse, neglect,	and exploitation. In addition to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245261	B. WING _	·····	12/	15/2016
	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283		
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F 226	Continued From particle freedom from a requirements in § 4 provide training to the educates staff on- (c)(1) Activities that exploitation, and management property as set forto (c)(2) Procedures for the educates forto (c)(2) Procedures for the educate forto (c)(3) Dementia management property (c)(4) Dementia manageme	age 4 abuse, neglect, and exploitation 183.12, facilities must also their staff that at a minimum It constitute abuse, neglect, isappropriation of resident h at § 483.12. For reporting incidents of abuse, n, or the misappropriation of anagement and resident abuse NT is not met as evidenced of and document review, the relop policies and procedures ag nursing home staff from otographs or recordings in any demean or humiliate a re to develop such shad the potential to affect all	F 22	F Tag 226 Staff Treatment of Re It is the policy Wood Dale Home develop and implement policies a procedures regarding screening training employees to prevent, ideand report abuse, neglect and mistreatment misappropriation of	sidents to and and entify,	
	defined mental abulimited to humiliatic punishment or depaddress prohibition and audio/video redemean or humiliation buring interview wir 12/12/16, at 2:55 p	e Prohibition Policy dated 8/12, use as: "this includes, but is not on, harassment, and threats of rivation." The policy did not of staff utilizing photographs cordings in a way that could		What corrective action will be accomplished for those residents have been affected by the deficie practice? There were no resident directly affected by the deficient processed to action will be that the Abuse Prohibition will be reviewed revised to include "prohibition of the of photographs and audio/video rin a manner that would demean of humiliate a resident, regardless of resident consent" will be prohibited employee hand book has also be	ent ts oractice. policy d and utilization material or of	

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NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	·	0, = 0.10
WOOD D	ALE HOME INC			600 SUNRISE BOULEVARD		
	ı			REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 226	of photographs and	d audio/video recordings in a	F 2	updated to include use of p		
	staff members, wa	•		recordings in any manner the demean or humiliate a residual prohibited.		
	Imaging of Reside The policy indicate protected from invo occur from the use videotapes, digital recorders during re	ig, Photographing and Other ints dated 9/06, was provided. It is a transfer of the transfer of		How will you identify other r having the potential to be a same deficient practice and corrective action to be take no residents directly affecte deficient practice.	ffected by the I what n? There were	
	resident." However prohibition of utiliza audio/video materi	r, the policy did not address ation of photographs and al in a manner that would te a resident, regardless of		What measures will be put what systemic changes will ensure that the deficient processor? The policy and processor Prohibition has been revised. The QA/QI Comm	be made to actice does not edure for reviewed and	
	"Refraining from so or on equipment w related as authoriz supervisor. The tal means at any Emp without express ac department superv owner. This is to p residents, our residents	dbook dated 10/16, directed to ocial media while on work time e provide, unless it is work ed by your department king of photographs by any cloyer's facilities is prohibited lyanced permission of a risor, the administrator or the rotect the privacy rights of our dents's family members and all employee handbook did not		review the policy to ensure components are present. I hand book that was reviewed as well to include the use of or recordings in any manned demean or humiliate a residence prohibited will also be reviewed. QA/QI Committee to ensure components are present. Swill be trained on 1/12/17.	all The employee and updated f photographs r that would dent is wed by the e all	
	address the use of any manner that w resident. During interview or administrator state cell phones and take is prohibited per the administrator further.	photographs or recordings in ould demean or humiliate a n 12/14/16, at 1:28 p.m. the d she taught staff that use of king photographs of residents e employee handbook. The er stated that she was aware of develop such specific policies;		How does the facility plan to performance to made sure are sustained? The policy Prohibition and the employer evisions will be reviewed a meeting. Who is responsible for this correction? The Director of designee will be responsible.	that solutions on Abuse ee hand book t next QA/QI plan of Nursing or	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		OATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 226 F 257 SS=D	requirements. The awaiting policy upda company that proving expected to receive 483.10(i)(6) COMFTEMPERATURE LIST (i)(6) Comfortable as Facilities initially cemust maintain a tendegrees F.	administrator stated to the new administrator stated she was ates from "Med Pass" a des policies, and was them later this month. ORTABLE & SAFE	F 226 F 257	compliance. Date of Correction: 1/23/17	1/23/17
	by: Based on observatoreview the facility farenvironment for 1 of complained of cold Findings include: During interview in 11:36 a.m. R29 stated also stated," They to degrees, but my row in here. I have to ke comes in from the Bouring additional in a.m. R29 stated it is that she had to have keep warm. During the environment of a.m. with main was a large, approximately for the 2 of exit door of the 2 of the state of t	ion, interview and document liled to ensure a comfortable of 2 residents (R29) who temperatures. R29's room on 12/14/16, at red "My feet are cold." R29 ell me the room temp is 75 om feels cool, its always cold pep the door shut, cold air		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 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 have been affected by the deficient practice? For Resident R29, she was asked if she wanted to move on 12/14/1 to a different room the outside temperature was -16. R29 at first said	to e of g

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245261	B. WING			12/	15/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOOD D	ALE HOME INC				REDWOOD FALLS, MN 56283		
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F 257	entry way door. During interview on stated the large gap had been there for y hallways are drafty feel the cold air con During interview on administrator stated the bottom of the enadministrator stated door sweep on the An undated form, Managed in Checklis column to check research	Id draft coming from under the 12/15/2016, at 9:20 a.m. M-A of under the 200 wing exit door years. M-A also verified the and cool and that she could ning in from under the door. 12/15/2016, at 10:52 a.m. the dishe was aware of the gap on and door on 200 wing. The dishe would have M-A install a door. Ionthly Maintenance the Resident Rooms included a sident room heat /units and e checklist did not include an	F 2	257	no, then she was shown room choi R29 chose to move to a new room. 205. That night R29 complained to nursing staff that it was too hot and On 12/15/16 R 29 stated that room hot and dry. A humidifier was put resident room on 12/16/16 for the cand heat. On 12/17/16 R 29 shared her room was too warm. R29, eventhough she stated new room was to had her legs wrapped in 3 or more blankets. Temperature of room he be taken every day for the room of Temperatures of area heating units taken daily and in resident rooms or residents that share they are cold. Also a draft prevention device, a do sweep, was installed in the gap on bottom of exit door of the 200 wing 12/15/16. How will you identify other resident having the potential to be affected same deficient practice and what corrective action will be taken? For residents who may be affected practice, checking of resident room temperatures will be added to the environmental checklist form and remade by the environmental staff for adjustment of room temperatures apprevention of cold drafts, for the coof the resident. Temperatures will maintained above 71 degrees during heating season. What measures will be put into place.	Room of dry. was in dryness d again no hot, at will R29. are of other or the on soy the by this ounds r the and mfort be ng the	
					what systemic changes will be made ensure that the deficient practice deficient practice deficient practice deficient practice deficient practice deficient practice deficient practice.	de to	

Facility ID: 00749

Event ID: S2Z511

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		245261	B. WING		12/	15/2016
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F 257	Continued From pa	ge 8	F 257	recur? The Monthly Maintenance Inspection Checklist Resident Roo been reviewed and revised by the Environmental Director on 1/3/17 to include checking of resident room temperatures in resident rooms on intermittent schedule. Environmental Staff will be trained as it relates to the respective roles and responsibilities before 1/20/17. How does the facility plan to monito performance to make sure that sol are sustained? Develop a plan for ensuring that correction is achieved sustained. This plan must be implemented, and the corrective acceptanted for its effectiveness. The of correction is integrated into the cassurance system. Audits of the monitoring of resident room temper will be completed by Environmentated Director weekly for four weeks, rais for two months. The results will be reported to the QA/QI Committee for two months. The recommendation Who is responsible for this plan of correction? The Environmental Director will be responsible for compliance.	an ental heir s or its utions d and etion e plan quality ratures l endomly or n.	
F 329 SS=D	483.45(d) DRUG R UNNECESSARY D	EGIMEN IS FREE FROM RUGS	F 329	Date of Correction: 1/23/17.		1/23/17
	drug regimen must	rugs-General. Each resident's be free from unnecessary sary drug is any drug when				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED		
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F 329	therapy); or (2) For excessive of (3) Without adequal (4) Without adequal (5) In the presence which indicate the of discontinued; or (6) Any combination paragraphs (d)(1) the This REQUIREMED by: Based on observative review, the facility for provide justification antidepressant med (R24) reviewed for Findings include: R24's quarterly Min 10/19/16, indicated impairment and min included diagnoses depression and indication in milligrams (mg) by	se (including duplicate drug	F 32	F TAge329 Unnecessary Drugs It is the policy of Wood Dale Home each resident's drug regimen is frounnecessary drugs. What corrective action will be accomplished for those residents have been affected by the deficier practice? For resident R24 a fax to her primary MD regarding the previously requested reduction in Zoloft and family decline along wit reasons why the family felt it would bad decision. Primary MD review information and noted that he was agreement with the reasons and to keep the Zoloft dose at current without a reduction at this time.	found to nt was sent her h the d be a ed the in decision dose	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283	•	
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F 329	During observation was smiling and comorning cares. R24's pharmacy of 5/12/16, suggested mg daily to 150 mg with this recomme change in dose. R24's progress no indicated the facilit decrease Zoloft to left for R22's daug R24's progress no indicated R24's dareduction in Zoloft anxiety) was just in R24's medical recommended and continued was in 200 mg's daily. RN recommended a dof 2016 and the phreduction in dose, refused the dose rephysician did not prontinued use of the During interview of the dose of	e dose of Zoloft since 6/2/15. If on 12/14/16, at 8:32 a.m. R24 conversing with staff during consult recommendation dated dia decrease in Zoloft from 200 g's daily. The physician agreed andation and authorized the dated 5/17/16, at 7:58 a.m. by received an order to 150 mg a day. A message was have to discuss. It detects 5/17/16, at 9:15 a.m. ughter did not want the as R22's Ativan (medication for	F3	having the potential to be a same deficient practice and corrective action will be tak residents who may be affect practice, the facility will reviresidents who are currently psychoactive medication to gradual dose reduction, and interventions, unless clinical contraindicated, in an effort these drugs has been comply what measures will be put what systemic changes will ensure that the deficient practur? The facility will revie policy for drug reduction to residents who use psychoal medication drugs receive greductions, and behavioral unless clinically contraindice effort to discontinue these of Licensed staff will be trained on reviewed policy. How the facility plans to make sure are sustained? Audits will monthly for the next three rewill utilize the MDS and Calquarterly schedule to ensure compliance. The results with the QA/QI Committee for further recommendation. Who is responsible for this correction? The Director of designee will be responsible compliance.	d what en? For other cted by this ew other taking a see that a d behavioral ally to discontinue oleted. into place or be made to actice does not ew and revise include ctive radual dose interventions, ated, in an drugs. d by 1/20/17 onitor its that solutions be completed nonths, facility re Conference te continued ill be reported or review and plan of f Nursing or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		(X3) DATE SURVEY COMPLETED	
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F 329	physician should be does not feel a dosa use is warranted, an	ge 11 recommendation, the e contacted with why the family age change for the medication and request that the physician on for continued use should be	F 32	Date of Correction: 1/23/2017		
F 334 SS=E		policy Drug Reduction, did not antidepressant medications. LUENZA AND IMMUNIZATIONS	F 33	4		1/23/17
		neumococcal immunizations acility must develop policies ensure that-				
	each resident or the receives education	ne influenza immunization, e resident's representative regarding the benefits and s of the immunization;				
	immunization Octob annually, unless the	offered an influenza per 1 through March 31 e immunization is medically the resident has already been his time period;				
		the resident's representative to refuse immunization; and				
		nedical record includes indicates, at a minimum, the				
		nt or resident's representative ation regarding the benefits ffects of influenza				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 334	immunization or dicimmunization due to refusal. (2) Pneumococcal of develop policies and (i) Before offering the immunization, each representative recebenefits and potent immunization; (ii) Each resident is immunization, unless medically contrained already been immunization or has the opportunity (iv) The resident or has the opportunity (iv) The resident's redocumentation that following: (A) That the resider was provided educated and potential side eximmunization; and (B) That the resider pneumococcal immunication or interested immunication or interest	and either received the influenza of not receive the influenza of medical contraindications or disease. The facility must disease. The facility must disease. The facility must disease. The facility must disease of the disease of the resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal is the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the ontion regarding the benefits effects of pneumococcal of the elimination or did not receive immunization or did not receive immunization due to medical received the immunization due to medical	F3	34		

		E SURVEY PLETED				
		245261	B. WING _	·····	12 /	15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283		
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F 334	Continued From particle Based on interview facilty failed to implicate Control (CDC) guide conjugate vaccine (R1,R8,R45) whose reviewed. Findings include: CDC identified adult have not previously received at least or (pneumococcal poldose of PCV13. The a dose of PCV13 syear after receipt of dose. R1's immunization pneumovax vaccindose on 1/2011 did PPSV23 or PCV13. R8's immunization pneumovax vaccin pneumovax vaccin	age 13 v and document review the lement the Center for Disease delines for pneumococcal (PCV13) for 3 of 5 residents e vaccination histories were Its ages 65 and older who had PCV13 and who have ne previous dose of PPSV23 lysaccharide) should receive a le recommendations indicated hould be given at least one f the most recent PPSV23 history record indicated a le dose was given 1/2011. The lanot specify whether it was led to specify whether it was	F 33	DEFICIENCY)	e to to luenza s that eives and nization. nza March 31 n is esident ng this y to nt attation at ntative g the cof received to sal.	DATE
	R45's immunization indicate whether are offered. During interview or director of nursing through each of the records and no correceived the PCV1 acknowledged some	n history record failed to ny pneumovax vaccine was 12/14/2016, at 2:45 p.m. the (DON) stated she had gone e resident's immunization offirmed no residents had 3 vaccine. The DON ne residents had received the The DON also stated the		practice? For residents R1, R8, and R45 th their representative was offered the recommended pneumococcal convaccine (PCV13) or the pneumococcal convaccine (PCV13) or the pneumococcal convaccine (PCV13) accord Center for Disease Control (CDC guidelines along with education rethe benefits and potential side effithe immunization. The immunization be administered to those who conto the immunization.	ey or ne njugated occal ing to) egarding ects of ion will	

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		245261	B. WING			12/1	15/2016
	PROVIDER OR SUPPLIER			60	REET ADDRESS, CITY, STATE, ZIP CODE 10 SUNRISE BOULEVARD EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	guidelines and state drafting a pneumocolanguage from the Control The facility's policy Vaccine dated 3/11/2 admission process pneumococcal vaccontraindicated or timmunized in the ladid not include currents.	ted about the PCV13 vaccine ed the facility was working on occal consent with the vaccine	F3	34	How will you identify other residents having the potential to be affected as same deficient practice and what corrective action will be taken? For residents a letter was sent out to all residents and/or representatives the facility was offering the recommence (PCV13) or the pneumococcal polysaccharide (PPSV23) according Center of Disease Control (CDC) guidelines along with education registed the immunization. The immunization be administered to those who constous to the immunization. What measures will be put into place what systemic changes will be made ensure that the deficient practice do recur? The facility will review and the pneumococcal immunization poinclude the current CDC guidelines to PCV13 and PPSV23 pneumococcovaccines. The facility will also updathere admission documentation to the current CDC guidelines related PCV13 and PPSV23 with the benepotential side effects so that reside and/or representatives can make a informed decision about the vaccin Licensed staff will be trained by 1/2 How does the facility plan to monitoperformance to make sure that solic are sustained? Develop a plan for ensuring that correction is achieved sustained. This plan must be implemented, and the corrective action is plan must be implemented.	or all I at the ded g to garding ets of n will ented ce or des not revise olicy to related eta include to fits and nts n ation. 10/17. or its utions d and	

Facility ID: 00749

Event ID: S2Z511

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		SURVEY PLETED
		245261	B. WING _		12/1	15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 SS=D	The facility must prodrugs and biologica them under an agre §483.70(g) of this punlicensed personn law permits, but onl supervision of a lice (a) Procedures. Af pharmaceutical senthat assure the accidispensing, and adi	n) DRUG RECORDS, UGS & BIOLOGICALS ovide routine and emergency ils to its residents, or obtain ement described in art. The facility may permit all to administer drugs if State y under the general ensed nurse.	F 43	evaluated for its effectiveness. The of correction is integrated into the cassurance system. Audits will be completed weekly for four weeks the monthly for three months with the rof findings at QA/QI Committee for recommendations. Who is responsible for this plan of correction? The Director of nursing or designed responsible for compliance. Date of Correction: 1/23/17 The charge nurse will verify the inspens are individually labeled upon receiving from pharmacy and if not immediately request labels to be detected to the facility.	quality nen review further e will be	1/23/17

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		E SURVEY IPLETED
		245261	B. WING			12/	15/2016
	PROVIDER OR SUPPLIER			600 S	ET ADDRESS, CITY, STATE, ZIP CODE UNRISE BOULEVARD WOOD FALLS, MN 56283	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	employ or obtain the pharmacist who (2) Establishes a syndisposition of all condetail to enable and an account of a maintained and performance and biological labeled in accordant professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance with facility must stolocked compartment controls, and perminave access to the controlled drugs list Comprehensive Drug Control Act of 1976 abuse, except when package drug distriquantity stored is more detailed to the control of the con	ation. The facility must e services of a licensed astem of records of receipt and introlled drugs in sufficient accurate reconciliation; and all controlled drugs is iodically reconciled. as and Biologicals. als used in the facility must be not with currently accepted alles, and include the ory and cautionary expiration date when as and Biologicals. with State and Federal laws, and biologicals in the state and biologicals in the state and biologicals in the state and personnel to keys. It provide separately locked, a compartments for storage of the din Schedule II of the and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F	131			
		ion. interview and document		F	Tag 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245261	B. WING		12/1	5/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	(medication to contappropriately prior residents (R38, R2) Findings include: R38's quarterly Minassessment dated type two diabetes reausing increase brequire insulin). R38's physican ord R38 received Humused for diabetes) times a day. R25's quarterly Min9/22/16, identified Imellitus. Review of R25's phidentified R25 reciemedication used for morning and 63 un During observation 12/13/16, at 9:45 at Levemir pens were	railed to ensure insulinated blood sugar) was labeled to administration for 2 of 2 5) reviewed who used insulin. Inimum Data Set (MDS) 11/18/16, identified R38 had nellitus (metabolic disease lood glucose levels which may lers dated 12/13/16, identified alog (type of insulin medication 10 units subcutaneously three himum Data Set (MDS) dated R25 had type two diabetes hysican orders dated 12/13/16, eved Levemir (type of insulinated in the evening. of the medication cart .m. R38's Humalog and R25's elocated in the medication cart	F 431	Labeling of Drugs and Biologicals What correction action will be accomplished for those residents for have been affected by the deficient practice? For resident R38 and R2 unlabeled insulin pens were immediscarded and new pens were operand labeled with resident initials, do opened and new expiration date. How will you identify other residents having the potential to be affected asame deficient practice and what corrective action will be taken? For residents who may be affected by the practice the facility reviewed all oth residents' medications that require labeling and documented date opecompliance. The facility sent writte notice to both local pharmacies that dispense insulin pens to open each and label each individual pen. What measures will be put into place what systemic changes will be made ensure that the deficient practice directive. The charge nurse will verify insulin pens are individually labeled receiving from pharmacy and if not	s the liately ned ate soy the rother his er ned for n t box ce or le to be not rother lupon	
	pen was not labele there an expiration which had been fille 11/8/16. R25's Leve R25's name.	eter cases. R38's Humalog d with R38's name nor was date located on the insulin pened by the pharmacy on emir pen was not labeled with 12/13/16, at 9:46 a.m. RN)-A stated all opened insulin		immediately request labels to be de to the facility. The policy and proce for medication labeling was reviewed revised. A review of this policy will reviewed by the Medical Director of ensure current standards of practic in place. A licensed nursing meeting be held by 1/20/17 to review revise and procedure.	edure ed and be : e are ng will	

PRINTED: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245261	B. WING			12/·	15/2016
	PROVIDER OR SUPPLIER			60	REET ADDRESS, CITY, STATE, ZIP CODE 10 SUNRISE BOULEVARD EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	and should include stated R38 and R28 insulin pens located When interviewed on RN-B also stated allabeled with the residate. RN-B stated the unlabeled/undated Further, RN-B stated days. During interview on director of nursing should be labeled with date when oper could become a "sa several residents of A facility policy on labeled with the date when oper could become a "sa several residents of A facility policy on labeled with the date when oper could become a "sa several residents of A facility policy on labeled with the date when oper could become a "sa several residents of A facility policy on labeled with the labeled with the date when oper could become a "sa several residents of A facility policy on labeled with the label	eled with the resident's name an expiration date. RN-A did not have any other in the medication cart. In 12/13/16, at 3:28 p.m. If opened insulin should be ident's name and expiration he facility had issues with insulin pens in the past. It is dinsulin pens expire after 28 at 12/13/16, at 3:34 p.m. the stated all new insulin pens with the resident's name and ned. Further, the DON stated it afety issue" as the facility had	F4	31	How the facility plans to monitor its performance to make sure that sol are sustained? Pharmacy audits we completed weekly for four weeks a monthly for three months to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendation. Who is responsible for this plan of correction? The Director of Nursin designee will be responsible for compliance. Date of Correction: 1/23/2017	utions vill be nd e or ns.	

Event ID: S2Z511

5261026

PRINTED: 01/06/2017 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245261 12/15/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 SUNRISE BOULEVARD WOOD DALE HOME INC **REDWOOD FALLS, MN 56283** (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1 ' '	DING 01 - MAIN BUILDING 01		COMPLETED		
		245261	B. WING _		12/	15/2016		
NAME OF PROVIDER OR SUPPLIER WOOD DALE HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
K 000	Angela.Kappenma <mailto:angela.ka 1.="" 1976,="" 2.="" 3.="" a="" a<="" actual,="" all="" and="" b="" bat="" be="" building="" co="" correct="" corridors="" dale="" defi="" deficiency="" department="" description="" detection="" determined="" facility="" fire="" following="" for="" fully="" has="" home="" in="" inf="" is="" mu="" name="" no="" notific="" of="" or="" p="" plan="" prevent="" reoccur="" resident="" responsible="" roon="" s="" single-station,="" td="" the="" to="" which="" with="" wood=""><td>estate.mn.us chitney@state.mn.us and an@state.mn.us appenman@state.mn.us appenman@state.mn.us> CORRECTION FOR EACH EST INCLUDE ALL OF THE CORMATION: If what has been, or will be, done ciency. Corroposed, completion date correction and monitoring to breaction and monitoring to breaction and monitoring to breaction and monitoring to breaction. Incorporated is a one-story assement. It was constructed in sprinkler protected and was of Type II(222) construction. If alarm system with smoke bridors and spaces open to the monitored for automatic fire cation. The facility also has attery operated smoke alarms in</td><td>K 00</td><td></td><td></td><td></td></mailto:angela.ka>	estate.mn.us chitney@state.mn.us and an@state.mn.us appenman@state.mn.us appenman@state.mn.us> CORRECTION FOR EACH EST INCLUDE ALL OF THE CORMATION: If what has been, or will be, done ciency. Corroposed, completion date correction and monitoring to breaction and monitoring to breaction and monitoring to breaction and monitoring to breaction. Incorporated is a one-story assement. It was constructed in sprinkler protected and was of Type II(222) construction. If alarm system with smoke bridors and spaces open to the monitored for automatic fire cation. The facility also has attery operated smoke alarms in	K 00					

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245261	B. WING		-	12/	15/2016
NAME OF PROVIDER OR SUPPLIER WOOD DALE HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SUNRISE BOULEVARD REDWOOD FALLS, MN 56283				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 918	NOT met by evider	t 42 CFR, Subpart 483.70(a) is		918			1/23/17
	Maintenance and The generator or o and associated equivaries within 10 scriterion is not met process shall be processed and transfer switches a with NFPA 110. Generator sets are under load 30 minuted load 30 minuted load conditions in the shall be simulated cold start transfer of all EES competent persons stored energy power accordance with Nicircuit breakers are program for period components is est manufacturer requirements and for the shall be set of the shall be shall be set of the shall be shall b	ther alternate power source uipment is capable of supplying econds. If the 10-second during the monthly test, a rovided to annually confirm this e safety and critical branches. esting of the generator and are performed in accordance inspected weekly, exercised ates 12 times a year in 20-40 exercised once every 36 hours. Scheduled test ons include a complete and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder e inspected annually, and a lically exercising the ablished according to irements. Written records of testing are maintained and EES electrical panels and d and readily identifiable. Esibility of damage of the source is a design lew installations. (NFPA 99), NFPA 110, NFPA			K918 Electrical Systems - Essent		

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

PRINTED: 01/06/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 245261 12/15/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **600 SUNRISE BOULEVARD** WOOD DALE HOME INC **REDWOOD FALLS, MN 56283** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION מו (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 918 Continued From page 3 K 918 Electric System the Facility failed to provide complete written A complete written record of Generator records of Generator maintenance and testing maintenance and testing will be are maintained and readily available. This maintained and readily available. deficient practice could affect 29 of 29 residents. The transfer of time of how long it takes the emergency generator to assume Electrical Systems - Essential Electric System power and the cool down time after the Maintenance and Testing generator does the 30 minute load test will The generator or other alternate power source be recorded. and associated equipment is capable of supplying service within 10 seconds. If the 10-second Proposed Completion date: January 23, criterion is not met during the monthly test, a process shall be provided to annually confirm this 2017 capability for the life safety and critical branches. Maintenance and testing of the generator and Environmental Director/Maintenance Director is responsible for correction and transfer switches are performed in accordance monitoring to prevent reoccurrence of this with NFPA 110. Generator sets are inspected weekly, exercised deficiency. 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:

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

PRINTED: 01/06/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			COMPLETED		
		245261	B. WING			12/1	5/2016
	PROVIDER OR SUPPLIER			60	REET ADDRESS, CITY, STATE, ZIP CODE 00 SUNRISE BOULEVARD EDWOOD FALLS, MN 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 918	On facility tour betwon 12/15/2016, door that not all the required documented during Generator Load Tellong it takes the enpower and the coordoes the 30 minute recorded.	ween 11:00 AM and 2:00 PM cumentation reviewed revealed uired information is being the Month Emergency est. The transfer time of how energency generator to assume I down time after the generator to load test is not being	K	918			



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 <u>only a suggestion</u> 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

Wood Dale Home, Inc. December 29, 2016 Page 2

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

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT COM		
		00749	B. WING		12/15/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
WOOD DA	ALE HOME INC		RISE BOULEVAR		
			DD FALLS, MN 5		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been			
	that may result from norders provided that a	earing on any assessments non-compliance with these written request is made to a 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesot	<u>a Department of Health</u>	n				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			B. WING			
		00749	B. WING		12/1	5/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TO AME OF TH	TO VIDER OR OUT FILER		, ,	,		
WOOD DA	ALE HOME INC		ISE BOULEVAR			
		REDWOOL	D FALLS, MN 5	56283		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR I	230 IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIL	DATE.
	 		 	,		
2 000	Continued From page	e 1	2 000			
		orders being submitted to				
		though no plan of correction				ı
	_	e Statutes/Rules, please				ı
	enter the word "corre	cted" in the box available for				ı
	text. You must then in	ndicate in the electronic				ı
	State licensure proce	ess, under the heading				ı
		date your orders will be				ı
		ctronically submitting to the				ı
	Minnesota Departmen	,				ı
		December 15th 2016,				ı
		artment's staff, visited the				ı
		ne following correction				ı
	T	_				ı
ļ	orders are issued. Pl	-			ļ	ı
	electronic plan of corr					ı
		s, and identify the date when				ı
	they will be completed					ı
	I	nt of Health is documenting				ı
	_	Correction Orders using				ı
	federal software. Tag					ı
	_	ta state statutes/rules for				ı
	Nursing Homes. The	assigned tag number				ı
	appears in the far left	column entitled "ID Prefix				ı
	Tag." The state statu	te/rule out of compliance is				ı
	listed in the "Summar	ry Statement of Deficiencies"				ı
	column and replaces	the "To Comply" portion of				ı
		This column also includes				ı
	the findings which are	e in violation of the state				1
	_	ment, "This Rule is not met				ı
		owing the surveyors findings				ı
		ethod of Correction and				1
	Time period for Corre					ı
		D THE HEADING OF THE				ı
						1
	FOURTH COLUMN V	,				ı
		OF CORRECTION." THIS				ı
		RAL DEFICIENCIES ONLY.				ı
	THIS WILL APPEAR					ı
	THERE IS NO REQU	JIREMENT TO SUBMIT A				I
	PLAN OF CORRECT	TION FOR VIOLATIONS OF				1
	MINNESOTA STATE	STATUTES/RULES.				1

Minnesota Department of Health

STATE FORM 6899 S2Z511 If continuation sheet 2 of 14

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			7 50.125.146.			
		00749	B. WING		12/1	5/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WOOD DA	LE HOME INC		ISE BOULEVA			
(X4) ID		ATEMENT OF DEFICIENCIES	D FALLS, MN 5	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
2 385	Continued From page	2	2 385			
2 385	MN Rule 4658.0200 S Residents; Mail	Subp. 3 Policies Concerning	2 385			
	unopened unless the legal guardian, conse payee, or other perso the resident has requ	dent must receive mail resident or the resident's rvator, representative n designated in writing by ested in writing that the mail tgoing mail must not be				
	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.					
	service designee (SS person delivers the grand newspapers on S mail is put on the SSI deliver on Mondays. residents who are the	ir own representative will s mail on Monday's when the				
	administrator stated n	2/14/6, at 2:01 p.m. the nail is delivered Monday e administrator stated				

Minnesota Department of Health STATE FORM

6899 S2Z511 If continuation sheet 3 of 14

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		00749	B. WING		12/1	5/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		600 SUNR	ISE BOULEVAI	RD		
WOOD DA	LE HOME INC		D FALLS, MN &			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
2 385	Continued From page	÷3	2 385	·		
		e mail determines what what personal mail is. The				
		under residents' rights all				
	mail should be deliver	•				
	The facility policy Mai	il dated 9/12, indicated mail				
		residents unopened unless				
	otherwise indicated by the attending physician					
		ne resident's medical record.				
		would be delivered to the				
	resident within twenty four hours of delivery on premises or to the facility's post office box					
	•	•				
	(including Saturday d	eliveries).				
	SUGGESTED METH	OD OF CORRECTION:				
		designee could review and				
		ding resident's mail and				
		staff regarding any changes				
		s receive their mail as				
	delivered, including o	n weekends.				
	TIME PERIOD FOR (CORRECTION: Twenty-one				
	(21) days.					
	, ,					
21535	MN Rule4658.1315 S	Subp.1 ABCD Unnecessary	21535			
	Drug Usage; General					
	0.1					
		A resident's drug regimen				
	must be free from unr unnecessary drug is a					
		ose, including duplicate drug				
	therapy;	,				
	B. for excessive	duration;				
		ate indications for its use; or				
		e of adverse consequences				
		se should be reduced or				
	discontinued.					
		g regimen review required in				
	part 4658.1310, the r	nursing home must comply				

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDIEAN	or dorace from	IDENTIFICATION NOWIDER.	A. BUILDING: _		OOWII E	
		00749	B. WING		12/1	5/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WOOD DA	ALE HOME INC		SE BOULEVAI			
	OLIMAN DV OT		FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	Code of Federal Regul 483.25 (1) found in Apl Operations Manual, Cong-Term Care Faci Department of Health Health Care Financing. This standard is incorravailable through the system and the State subject to frequent characteristics. This MN Requirement by: Based on observation review, the facility fail provide justification for antidepressant medic (R24) reviewed for un Findings include: R24's quarterly Minim 10/19/16, indicated R impairment and mild concluded diagnoses of depression and indicated antidepressant. R24's Order Summar physician on 12/9/16, Zoloft (medication use milligrams (mg) by medisorder. The orders in the state of	Interpretive Guidelines for ulations, title 42, section opendix P of the State Guidance to Surveyors for lities, published by the and Human Services, g Administration, April 1992. porated by reference. It is Minitex interlibrary loan Law Library. It is not ange. It is not met as evidenced in, interview and document ed to initiate a taper, or or continued use, of ations for 1 of 5 residents inecessary medications.	21535			
		n 12/14/16, at 8:32 a.m. R24 ersing with staff during				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA CC			JRVEY TED
	00749	B. WING		12/15	5/2016
NAME OF PROVIDER OR SUPPLIER WOOD DALE HOME INC	600 SUNF	DRESS, CITY, STAT	RD		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
5/12/16, suggested a mg daily to 150 mg's owith this recommendate change in dose. R24's progress note of indicated the facility redecrease Zoloft to 150 left for R22's daughter R24's progress note of indicated R24's daughter reduction in Zoloft as anxiety) was just increased and continued day. During interview on 12 registered nurse (RN) R24's Zoloft was increased and the physical reduction in dose. RN refused the dose reduphysician did not provocontinued use of the 2 During interview on 12 director of nursing state with the pharmacy recophysician should be codoes not feel a dosaguse is warranted, and	ult recommendation dated decrease in Zoloft from 200 daily. The physician agreed ation and authorized the dated 5/17/16, at 7:58 a.m. eceived an order to 0 mg a day. A message was in to discuss. dated 5/17/16, at 9:15 a.m. eter did not want the R22's Ativan (medication for lased. lack any justification for lase of Zoloft 200 mg's a 2/15/16, at 10:07 a.m. eased from 100 mg's daily to stated the pharmacist ereduction for Zoloft in May cian had ordered the e-B further stated the family action, and that the ride a justification for Zoloft at 200 mg daily. 2/15/16, at 10:14 a.m. the ted that if a family disagrees	21535			

Minnesota Department of Health STATE FORM

S2Z511 If continuation sheet 6 of 14

Minnesota Department of Health

	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		00749	B. WING		12/1	5/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		600 SUNR	ISE BOULEVAI	RD		
WOOD DALE HOME INC REDWOO			D FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21535	Continued From page 6		21535			
	address tapering of a SUGGESTED METH The Director of Nursir develop, review, and/ procedures to ensure reviewed for gradual of medication. The Di designee could educa the policies and proce	or revise policies and residents' drug regimes are dose reduction and tapering rector of Nursing or ate all appropriate staff on edures. The Director of could develop monitoring going compliance.				
21620	MN Rule 4658.1345 L Drugs used in the nur in accordance with pa	rsing home must be labeled	21620			
	by: Based on observatior review, the facility fail (medication to control appropriately prior to residents (R38, R25) Findings include: R38's quarterly Minim assessment dated 11 type two diabetes me	l blood sugar) was labeled administration for 2 of 2 reviewed who used insulin.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00749	B. WING		12/15/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
WOOD DA	LE HOME INC		SE BOULEVAR			
	OUN MAN DV OT		FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21620	Continued From page	e 7	21620			
	R38 received Humald used for diabetes) 10 times a day. R25's quarterly Minim	s dated 12/13/16, identified og (type of insulin medication units subcutaneously three num Data Set (MDS) dated had type two diabetes				
	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.					
	pens should be labeled and should include an)-A stated all opened insulin ed with the resident's name n expiration date. RN-A did not have any other				
	RN-B also stated all clabeled with the residedate. RN-B stated the unlabeled/undated ins	12/13/16, at 3:28 p.m. opened insulin should be ent's name and expiration a facility had issues with sulin pens in the past. insulin pens expire after 28				

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/15/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WOOD DA	LE HOME INC		SE BOULEVAR		
			FALLS, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21620	Continued From page 8		21620		
	director of nursing sta should be labeled with the date when opened	eling and storing of			
	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				
		oroperly. The DON or the pharmacist, could audit alar basis to ensure			
	TIME PERIOD FOR 0 (21) days.	CORRECTION: Twenty one			
21705	MN Rule 4658.1415 S Housekeeping, Opera		21705		
	maintain the mechanicomfortable and safe and humidity levels. Tareas must be mainta C: A. For construction	g home must operate and cal systems to provide temperatures, air changes, emperatures in all resident ined according to items A to on of a new physical plant, a aintain a temperature range heit to 81 degrees			

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		00749	B. WING		12/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WOOD DA	ALE HOME INC		ISE BOULEVAI D FALLS, MN(
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21705	B. For existing fa must maintain a mini degrees Fahrenheit d C. Variations of the items A and B are allo based on documenter. This MN Requirement by: Based on observation review the facility failed environment for 1 of 2 complained of cold ter. During interview in R 11:36 a.m. R29 stated also stated," They tell degrees, but my room in here. I have to kee comes in from the half buring additional intered a.m. R29 stated it still that she had to have skeep warm. During the environment 9:16 a.m. with maintered was a large, approximate of exit door of the 200 the door was an entry door. There was cold entry way door. During interview on 1 stated the large gap thad been there for years.	cilities, a nursing home mum temperature of 71 uring the heating season. It temperatures required by lowed if the variations are differences. It is not met as evidenced and interview and document led to ensure a comfortable 2 residents (R29) who imperatures. 29's room on 12/14/16, at difference are cold." R29 imme the room temp is 75 in feels cool, its always cold pethe door shut, cold air	21705			

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Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00749	B. WING		12/15/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
WOOD DA	ALE HOME INC	600 SUN	RISE BOULEVAR	RD	
11000 07	TEL HOME ING	REDWOO	DD FALLS, MN 5	6283	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21705	Continued From page	e 10	21705		
	feel the cold air comir	ng in from under the door.			
	administrator stated s the bottom of the end	2/15/2016, at 10:52 a.m. the he was aware of the gap on door on 200 wing. The he would have M-A install a or.			
	column to check resid	Resident Rooms included a lent room heat /units and checklist did not include an			
	The environmental se	OD OF CORRECTION: rvices director (ED), could ure room temperatures are ents.			
	TIME PERIOD FOR (one (21) days.	CORRECTION: Twenty -			
22000	MN St. Statute 626.5 Reporting - Maltreatm	57 Subd. 14 (a)-(c) ent of Vulnerable Adults	22000		
	facility, except home I personal care attenda establish and enforce prevention plan. The assessment of the ph environment, and its practors which may enand a statement of sp	ant services providers, shall an ongoing written abuse plan shall contain an ysical plant, its copulation identifying courage or permit abuse, ecific measures to be taken f abuse. The plan shall			
	promulgated by the lid (b) Each facility, ind				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/15/2016	
NAME OF P	ROVIDER OR SUPPLIER		L RESS, CITY, STA	TE. ZIP CODE	12/1	3/2010
WOOD DA	ALE HOME INC		SE BOULEVAR			
WOOD DA	ALL HOME ING	REDWOOD	FALLS, MN 5	56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
22000	Continued From page 11 providers, shall develop an individual abuse		22000			
	prevention plan for ea					
	The plan shall contain	iving services from them. n an individualized				
	assessment of: (1) th	e person's susceptibility to				
	abuse by other individ	duals, including other the person's risk of abusing				
	other vulnerable adult	ts; 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.					
	by: Based on interview ar facility failed to develo	t is not met as evidenced nd document review, the pp policies and procedures nursing home staff from				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ΓED
		00749	B. WING		12/15	/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WOOD D	LE LIONE INC	600 SUNR	ISE BOULEVAI	RD		
WOOD DA	ALE HOME INC	REDWOO	D FALLS, MN &	56283		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETE DATE
22000	Continued From page	e 12	22000			
	taking or using photog manner that would de resident. The failure t	graphs or recordings in any emean or humiliate a o develop such ad the potential to affect all				
	Findings include:					
	defined mental abuse limited to humiliation, punishment or depriva address prohibition of	rohibition Policy dated 8/12, eas: "this includes, but is not harassment, and threats of ation." The policy did not f staff utilizing photographs rdings in a way that could 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.					
	Imaging of Residents The policy indicated t protected from invasio occur from the use of videotapes, digital image recorders during resident activities without the v resident." However, th prohibition of utilizatio audio/video material i	Photographing and Other dated 9/06, was provided. hat "Residents will be on of privacy that might resident photographs, ages , and other visual dent care or other facility written consent of the ne policy did not address on of photographs and n a manner that would a resident, regardless of				
	"Refraining from socia	ook dated 10/16, directed to al media while on work time provide, unless it is work				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/15/2016	
	ROVIDER OR SUPPLIER	600 SUNRI	RESS, CITY, STA SE BOULEVAI FALLS, MN &	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
22000	means at any Employ without express advardepartment supervisor owner. This is to prote residents, our resident employees." The empaddress the use of phany manner that woul resident. During interview on 1: administrator stated seell phones and taking is prohibited per the eadministrator further set the requirement to dehowever, did not have requirements. The administrator or company that provide expected to receive the suggested to receive the suggested to include the administrator or composition of the suggested to the suggested to ensure staff on these policy administrator or designation of the suggested to ensure staff and procedures.	by your department g of photographs by any per's facilities is prohibited inced permission of a per, the administrator or the pect the privacy rights of our ts's family members and all ployee handbook did not protographs or recordings in didemean or humiliate a photographs of residents per photographs per photograp	22000			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/1	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
WOOD	PALE HOME INC		ISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	*****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and	nether a violation has been				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/09/17 **Electronically Signed**

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TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71110 1 127111	or connection	BENTH TO A TOTAL TOTAL	A. BUILDING:		00.11.11	
		00749	B. WING		12/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOOD	NALE HOME INC	600 SUNR	ISE BOULE	VARD		
WOODL	DALE HOME INC	REDWOO	D FALLS, M	N 56283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 000	Continued From page 1		2 000			
	Department of Hearyou electronically, is necessary for State necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to electronic Department on December 12th surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ord they will be complemented to Minnesota Department the State Licensing federal software. The state Licensing federal software. The state Licensing federal software in the far leading to Minnesota Departmented to Minnesota D	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. - December 15th 2016, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. In ent of Health is documenting ag numbers have been sota state statutes/rules for the assigned tag number eff column entitled "ID Prefix attute/rule out of compliance is the "To Comply" portion of the state are in violation of Correction and crection. IRD THE HEADING OF THE				

Minnesota Department of Health STATE FORM

FORM S2Z511 If continuation sheet 2 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
			B. WING		42/42/2242	
		00749			12/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S RISE BOULE	STATE, ZIP CODE		
WOOD D	ALE HOME INC		D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 385	Continued From pa	ge 2	2 385			
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail		2 385			1/3/17
	unopened unless the legal guardian, conspayee, or other personant the resident has recommended.	esident must receive mail ne resident or the resident's servator, representative son designated in writing by quested in writing that the mail outgoing mail must not be				
	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.			Corrected		
	Findings include:					
	residents (R)-25 an	12/14/16, at 1:53 p.m. d R-27 both stated they were was delivered on Saturday's.				
	service designee (Sperson delivers the and newspapers or mail is put on the Specific deliver on Mondays residents who are the receive their busines SSD comes into the					
	administrator stated	12/14/6, at 2:01 p.m. the d mail is delivered Monday The administrator stated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00749	B. WING		12/1	15/2016
_	PROVIDER OR SUPPLIER	600 SUNF	DRESS, CITY, S RISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 385	whoever is sorting to business mail is and administrator stated mail should be delivered of the facility policy Mould be delivered of the facility policy of the facility of th	he mail determines what d what personal mail is. The d under residents' rights all vered to all residents. Itali dated 9/12, indicated mail to residents unopened unless by the attending physician the resident's medical record. il would be delivered to the aty four hours of delivery on acility's post office box deliveries). IHOD OF CORRECTION: or designee could review and arding resident's mail and to staff regarding any changes ants receive their mail as	2 385			
21535	Drug Usage; General Subpart 1. General must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the present which indicate the codiscontinued. In addition to the discontinued of the continued of the	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug	21535			1/3/17

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00749	B. WING		10/1	E/2016
NAME OF				CTATE ZID CODE	12/1	5/2016
	PROVIDER OR SUPPLIER		RISE BOULE	STATE, ZIP CODE VARD		
WOOD	DALE HOME INC		D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE	(X5) COMPLETE DATE
21535	with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Faderal Department of Health Care Finance This standard is incavailable through the system and the Stasubject to frequent This MN Requirembly: Based on observation antidepressant med (R24) reviewed for Findings include: R24's quarterly Min 10/19/16, indicated impairment and mill included diagnoses depression and indantidepressant. R24's Order Summin physician on 12/9/1 Zoloft (medication of milligrams (mg) by disorder. The order receiving the same During observation.	ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not	21535	Corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOOD D	ALE HOME INC		RISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
21535	Continued From page 5		21535			
	5/12/16, suggested mg daily to 150 mg with this recommen change in dose. R24's progress note	nsult recommendation dated a decrease in Zoloft from 200 s daily. The physician agreed dation and authorized the e 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.					
		rd lack any justification for ed use of Zoloft 200 mg's a				
	registered nurse (R R24's Zoloft was ind 200 mg's daily. RN- recommended a do of 2016 and the phy reduction in dose. F refused the dose re physician did not pr	12/15/16, at 10:07 a.m. N)-B stated that on 6/2/15, creased from 100 mg's daily to B stated the pharmacist se reduction for Zoloft in May visician had ordered the RN-B further stated the family duction, and that the ovide a justification for e Zoloft at 200 mg daily.				
	director of nursing s with the pharmacy in physician should be does not feel a dos use is warranted, a	12/15/16, at 10:14 a.m. the stated that if a family disagrees recommendation, the contacted with why the family age change for the medication of request that the physician on for continued use should be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00749	B. WING		19/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	12/1	3/2010
WOOD D	ALE HOME INC		RISE BOULE			
	I		D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 6	21535			
		policy Drug Reduction, did not antidepressant medications.				
	The Director of Nur develop, review, an procedures to ensu reviewed for gradua of medication. The designee could edu the policies and pro Nursing or designee	THOD OF CORRECTION: sing or designee could d/or revise policies and re residents' drug regimes are al dose reduction and tapering Director of Nursing or locate all appropriate staff on ocedures. The Director of e could develop monitoring ongoing compliance.				
	TIME PERIOD FOR Twenty-One (21) D					
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			1/3/17
	Drugs used in the r in accordance with	nursing home must be labeled part 6800.6300.				
	by: Based on observati review, the facility for (medication to cont appropriately prior t	ent is not met as evidenced on, interview and document ailed to ensure insulin rol blood sugar) was labeled to administration for 2 of 2 5) reviewed who used insulin.		Corrected		
	Findings include:					
	assessment dated type two diabetes n	imum Data Set (MDS) 11/18/16, identified R38 had nellitus (metabolic disease lood glucose levels which may				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/1	5/2016
	PROVIDER OR SUPPLIER	600 SUNR	DRESS, CITY, S ISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	R38's physican order R38 received Human used for diabetes) of times a day. R25's quarterly Min 9/22/16, identified Findlitus. Review of R25's phidentified R25 reciemedication used for morning and 63 unity During observation 12/13/16, at 9:45 a. Levemir pens were inside their glucome pen was not labeled there an expiration which had been filled 11/8/16. R25's Lever R25's name. During interview on registered nurse (R pens should be laberated R38 and R25 insulin pens located.)	ers dated 12/13/16, identified alog (type of insulin medication 10 units subcutaneously three imum Data Set (MDS) dated 325 had type two diabetes ysican orders dated 12/13/16, ved Levemir (type of insulin r diabetes) 56 units in the	21620	DEFICIENCY)		
	RN-B also stated al labeled with the res date. RN-B stated the unlabeled/undated in	I opened insulin should be ident's name and expiration he facility had issues with insulin pens in the past.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		00749	B. WING		12/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WOOD D	ALE HOME INC		RISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	During interview on director of nursing is should be labeled with the date when oper could become a "sa several residents on A facility policy on lamedications was reprovided. SUGGESTED MET administrator, direct consulting pharmace policies and proced labeling of medication educated as necessabeling medication designee, along with medications on a recompliance.	12/13/16, at 3:34 p.m. the stated all new insulin pens with the resident's name and ned. Further, the DON stated it afety issue" as the facility had	21620			
21705	Subp. 6. Heating, a ventilation. A nursi maintain the mecha comfortable and sa and humidity levels areas must be mair C: A. For construct nursing home must	eration, & Maintenance air conditioning, and ing home must operate and anical systems to provide fe temperatures, air changes, . Temperatures in all resident intained according to items A to etion of a new physical plant, a maintain a temperature range enheit to 81 degrees	21705			1/3/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WOOD	OALE HOME INC		RISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21705	must maintain a m degrees Fahrenheir C. Variations of t items A and B are a based on documen This MN Requirements. Based on observation review the facility farenvironment for 1 complained of cold Findings include: During interview in 11:36 a.m. R29 stated, They to degrees, but my row in here. I have to ke comes in from the buring additional in a.m. R29 stated it storage and the state of exit door of the 2 the door was an endoor. There was constated the large gap.	facilities, a nursing home inimum temperature of 71 to during the heating season. The temperatures required by allowed if the variations are ted resident preferences. The ten is not met as evidenced and interview and document alled to ensure a comfortable of 2 residents (R29) who temperatures. The ten is not met as evidenced and interview and document alled to ensure a comfortable of 2 residents (R29) who temperatures. The ten is not met as evidenced and interview and document alled to ensure a comfortable of 2 residents (R29) who temperatures.	21705	Corrected		

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STATE FORM S2Z511 If continuation sheet 10 of 14

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00749	B. WING		12/1	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WOOD D	ALE HOME INC		RISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 10	21705			
	feel the cold air con	ning in from under the door.				
	administrator stated the bottom of the en	12/15/2016, at 10:52 a.m. the d she was aware of the gap on and door on 200 wing. The d she would have M-A install a door.				
	Inspection Checklis column to check res	Monthly Maintenance at Resident Rooms included a sident room heat /units and e checklist did not include an temperatures.				
	The environmental	THOD OF CORRECTION: services director (ED), could nsure room temperatures are idents.				
	TIME PERIOD FOR one (21) days.	R CORRECTION: Twenty -				
22000		5.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			1/3/17
	facility, except hom personal care attent establish and enforce prevention plan. The assessment of the environment, and it factors which may earn a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility,	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00749	B. WING		12/1	5/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
WOOD D	ALE HOME INC		RISE BOULE D FALLS, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
22000	prevention plan for residing there or retaining there or retains the plan shall contrassessment of: (1) abuse by other indivulnerable adults; (1) other vulnerable adspecific measures the risk of abuse to that adults. For the purterm "abuse" include (c) If the facility, and personal care a knows that the vulnerable to the plan must detail the minimize the risk the reasonably be expendicility and persons unsupervised. Under the plan must detail the minimize the risk the reasonably be expendicility and persons unsupervised. Under the plan must detail the minimize the risk the reasonably be expendicility and persons unsupervised. Under the plan must detail the minimize the risk the reasonably be expendicility and persons unsupervised. Under the plan must detail the minimize the risk the reasonably of a vulnerable adult misconduct or physical minimizer.	elop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the	22000				
	by: Based on interview facility failed to deve	and document review, the elop policies and procedures g nursing home staff from		Corrected			

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STATE FORM S2Z511 If continuation sheet 12 of 14

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY MPLETED	
		00749	B. WING		12/1	5/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADD WOOD DALE HOME INC. 600 SUNR			ISE BOULE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D FALLS, M ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
22000	taking or using phomanner that would resident. The failure policies/procedures 28 residents residint. Findings include: The facility's Abuse defined mental abulimited to humiliatio punishment or depraddress prohibition and audio/video redemean or humiliat. During interview wit 12/12/16, at 2:55 p. conference, the polof photographs and way that could dem staff members, was A policy Videotaping Imaging of Resident The policy indicated protected from invaloccur from the use videotapes, digital i recorders during reactivities without the resident." However, prohibition of utiliza audio/video materia demean or humiliat resident consent. An Employee Hand "Refraining from so	tographs or recordings in any demean or humiliate a e to develop such had the potential to affect all ing in the facility. Prohibition Policy dated 8/12, se as: "this includes, but is not in, harassment, and threats of rivation." The policy did not of staff utilizing photographs cordings in a way that could be residents. In the director of nursing on in. during the entrance icy prohibiting staff utilization audio/video recordings in a ean or humiliate residents by	22000				

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STATE FORM S2Z511 If continuation sheet 13 of 14

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00749	B. WING		12/1	5/2016
	PROVIDER OR SUPPLIER	600 SUNF	DRESS, CITY, S RISE BOULE D FALLS, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	related as authorize supervisor. The tak means at any Empl without express addepartment superviowner. This is to presidents, our residents, our residemployees." The eraddress the use of any manner that woresident. During interview on administrator stated cell phones and tak is prohibited per the administrator furthed the requirement to however, did not have requirements. The awaiting policy upda company that provide expected to receive SUGGESTED MET. The administrator of policies related to propose developed to include the administrator of staff on these policy administrator or desaudit to ensure staff and procedures.	ge 13 ed by your department ing of photographs by any oyer's facilities is prohibited vanced permission of a sor, the administrator or the otect the privacy rights of our ents's family members and all imployee handbook did not photographs or recordings in ould demean or humiliate a see that the dishe taught staff that use of ing photographs of residents employee handbook. The er stated that she was aware of develop such specific policies; are a policy related to the new administrator stated she was attes from "Med Pass" a des policies, and was a them later this month. THOD OF CORRECTION: or designee could ensure otential resident abuse were all forms of potential abuse. Or diesignee could educate all y and procedures. The signee could then monitor and f adherence to the policies. R CORRECTION: Twenty-one	22000			

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