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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VQHJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00749

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, HFE NE II 03/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 04/01/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/06/2016 Co.cjo

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245261
April 1, 2016

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

Dear Ms. Sandmann:

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

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

Effective March 4, 2016 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 1, 2016

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

RE: Project Number S5261026

Dear Ms. Sandmann:

On February 10, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 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 March 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 10, 2016 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 January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 4, 2016 and therefore remedies outlined in our letter to you dated February 10, 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.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245261 Y1	A. Building B. Wing Y2	3/22/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0314	Correction	ID Prefix F0329	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed
LSC	03/04/2016	LSC	03/04/2016	LSC	03/04/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/04/2016	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 STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	BF/KJ	04/01/2016	10562	03/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245261 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/10/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	03/04/2016	LSC K0050	03/04/2016	LSC K0054	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0056	03/04/2016	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 STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	BF/KJ	04/01/2016	10562	03/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/27/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VQHJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00749

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/28/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NE II 03/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/`10/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2694
February 10, 2016

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

RE: Project Number S5261026

Dear Ms. Sandmann:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, 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 March 8, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 28, 2016 (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 July 28, 2016 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	01/28/2016

RECEIVED
FEB 24 2016
MN Dept of Health
St Cloud

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	See Attached 3/1/16 JA	3/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judith Handmann — TITLE: ADMINISTRATOR — (X6) DATE: 2-22-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	01/28/2016

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

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required liability and appeal notice of Medicare non-coverage for 1 of 3 residents (R18) reviewed who had a qualifying Medicare A stay. Findings include: R18's Therapist Progress and Discharge Summary dated 10/13/15, indicated she had participated in physical therapy from 9/9/15 through 10/13/15. In addition, the summary indicated R18 had met her ambulation and strength goals and was able to discharge to an assisted living facility with help. R18's Transfer/Discharge Report dated 10/14/15, indicated she had been admitted on 9/8/15, and was discharged on 10/14/15. There was no record of a Notice of Medicare Provider	F 156		

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F 156	Continued From page 3 Non-coverage (CMS-10123) being given to R18 two days before discharge from therapy services. When interviewed on 1/27/16, at 11:54 a.m. the director of nursing (DON) stated she could not find the signed Notice of Medicare Provider Non-coverage (CMS-10123). The DON further stated that R18 should have received notification at least 48 hours prior to therapy services ending. The DON stated she was not sure why that hadn't happened, she (the DON) had just missed it. The undated facility policy Medicare Denial Letters, indicated notice of Medicare non-coverage "must be given 48 hours in advance of discharge from skilled service." In addition, the policy indicated the facility was to "keep copy for Medicare file."	F 156		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a resident's skin in order to develop an appropriate turning/ repositioning schedule to prevent pressure ulcers	F 314	See Attached	3-4-16

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F 314	Continued From page 4 from developing and/ or to promote healing of current pressure ulcers, for 1 of 1 resident (R23) reviewed who had a current pressure ulcer. Findings include: During Stage 1 staff interview on 1/25/16 at 3:38 p.m., licensed practical nurse (LPN)-A stated that R23 did not have any skin concerns or pressure ulcers. R23's record was reviewed. R23's diagnoses list included a diagnosis of end stage chronic obstructive pulmonary diease. A quarterly Minimum Data Set (MDS) assessment dated 12/3/15, indicated R23 was severely cognitively impaired and totally dependant on 1-2 staff for all activities of daily living (ADLs). A significant change MDS had also been conducted for R23 in September 2015. Care Area Assessments (CAAs) for ADLs and Pressure Ulcer had been triggered. However, when the CAA documentation was reviewed, only ADLs had been considered for care planning. During morning resident care observations on 1/27/16 at 8:14 a.m., two nursing assistants (NA)-A and NA-B entered the room to provide morning cares. While cares were being provided, a hospice nursing assistant NA-C arrived and and began to assist. After R23's peri and rectal care had been completed, NA-A applied a zinc oxide 10% barrier spray to R23's buttocks. NA-C told NA-A she thought R23's pressure ulcer had already healed, but NA-A clarified it had not. During the observation, a small pea size area was noted where the pressure ulcer had been. NA-A was interviewed on 1/27/16 at 9:28 a.m..	F 314		

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F 314	Continued From page 5 NA-A stated, "it [the pressure ulcer] use to be a lot bigger than it is. It is now about 1/2 the size it was." NA-A stated they were using a barrier spray and an air mattress for R23's skin. When asked about R23's repositioning schedule, NA-A stated that staff repostion R23 "every two hours." In review of R23's electronic record progress notes, a note from 12/2/15 at 3:24 p.m. included: "[R23] has a small red area on his buttocks. He is repositioned in bed often, and placed in his broda chair when he wants to get up. Sensacare is used on this area. Will continue to monitor. Tissue Tolerance sheet started." The next electronic record progress note was entitled, "monthly charting" dated 12/24/15 at 3:30 a.m.. The monthly charting documentation included: "resident has episodes during night of restlessness related to his pain and sometimes becones (sig) aggitated requiring medication of morphine for pain and ativan for anxiety, which he also recieves on other times diring (sig) 24 hour period.....skin condition he has a small open sore on his coccyx area that we are spraying a skin barrier to, also his right shin has a healed/scabed abrasion area...has a special mattress on/air which helps skin breakdown...." The facility had completed a Braden assessment (a scale to assess the level of risk for development of pressure ulcers) on 12/2/15, which indicated the resident had scored 12 and was at high risk for the development of pressure ulcers. The facility's weekly skin assessment documentation for R23 included:	F 314		

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F 314	Continued From page 6 12/7/15 - Small red area on buttocks, right lower leg 3+ edema red and warm to the touch, treating with antibiotics, suspect cellulitus. 12/14/15 - #23 site appears dime size; applying Sensicare. Will contact Hospice to inform. Stage II. 12/21/15 - #23 site appears dime size; applying Sensicare. Will contact Hospice to inform. Stage II. 12/28/15 - No new skin issues noted with this audit. Still has open area to buttocks/small. Using barrier spray and has air mattress overlay. No c/o (complaints of) pain r/t (related to) open area. 1/4/16 - small abraision on left cheek dime sized covering with padded Tegaderm and bacitracin.Still has open area to buttocks/small. Using barrier spray and has air mattress overlay. 1/18/16 - Still has open area to buttocks/small. Using barrier spray and has air mattress overlay. 1/25/16 - Still has open area to buttocks/small. Using barrier spray and has air mattress overlay None of these Skin Observation notes included any specific measurements. Although the wound was identified as Stage II in some of the entries, no other assessment information was located in the resident's record. The facility's Skin/Pressure Ulcer Policy (last updated 2/2/09), included: "Further assessments will be made after admission, including a skin audit assessment [every week] for the 1st 4 [weeks] on the resident's skin. Further assessments will be made at the end of the intial 7-day assessment period, and with quarterly and full MDS assessments, within the 7-day assessment period...When a wound is identified, a comprehensive wound assessment will be	F 314		

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F 314	Continued From page 7 completed. This assessment will include: a) Site, stage, size, appearance of wound bed, (use%) undermining, depth, drainage, (amount, color, type, consistency and odor and status of peri-wound tissue. b) Treatment of the pressure ulcer, (cleansing, debridement, dressings, c) Use of PUSH tool to assess healing. d) A critical review of the resident's current care plan and medical status - any other possible risk factors, impaired healing [due to] diagnoses, e) Type of Skin Ulcer (have MD identify if a stasis (venous) or ischemic (arterial) skin ulcer and get MD's input and order for the care of the ulcer. Reassess the wound at least weekly; include a)-c) above. (If the wound has not improved within 2-3 weeks, contact MD for a change in treatment.)" During interview on 1/27/16 at 12:40 p.m., registered nurse (RN)-A stated skin assessment and measurement, for residents with pressure ulcers, occurs on bath days. RN-A verified she had completed a skin assessment on 12/14/15, but did not realize she had not documented R23's wound measurements and should have. RN-A confirmed the facility policy is that they are to measure wounds weekly until healed. In an interview on 1/27/16 at 12:45 p.m., licensed practical nurse (LPN)-A stated she had completed five of the seven weekly assessments. LPN-A also stated had not documented the sizes of R23's wound, other than describing the wound as "dime size." LPN-A was asked about the assessment from 1/4/16, which documented that there were two separate treatment types ("covering with padded tegaderm and bacitracin. Still has open area to buttocks/small. Using barrier spray") to which she stated she did not	F 314		

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F 314	Continued From page 8 remember writing. LPN-A stated they had been using Sensicare, however after having received a sample spray with 10% zinc oxide, had begun using that product. LPN-A was unable to produce treatment orders for either of the wound products used in the treatment of R23's wound. LPN-A stated she did not consider the skin described in the first skin assessment completed on 12/7/15, as open. LPN-A stated the skin just had an abraision where the top layer of skin was missing. However, after review of the descriptions, stated it should have been identified as a stage 2. When asked about the 12/21/15 assessment, in which LPN-A identified the wound as a Stage 2, LPN-A stated she was uncertain why she had documented it that way. LPN-A stated she had not had an RN review the wound because she hadn't thought of it as an open area. During interview on 1/27/16 at 1:35 p.m., the director of nursing (DON) stated she was unaware of R23's pressure ulcer. The DON stated that while she does the wound rounds, R23 had not been on her list for review. The DON's understanding was that R23 had a reddened area from bowel and bladder incontinence that staff were monitoring, otherwise she would have been ensuring it was measured during wound rounds. In a subsequent interview on 1/27/16 at 2:05 p.m., the DON provided an undated facility form, Assessment Check Off List, which the facility utilized during MDS assessment periods. The check off sheet indicated the facility had performed the Braden assessment and a skin assessment with narrative note. A Tissue Tolerance Test (an assessment used to determine the period of time a resident can sit/lay	F 314		

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F 314	Continued From page 9 without repositioning), had been initiated on 12/2/15, however had not been completed. The DON said the care manager who had initiated the check off list no longer works for the facility. The DON also stated a tissue tolerance test should have been completed to determine an appropriate repositioning schedule for R23.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	See Attached	3-4-16

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F 329	Continued From page 10 Based on observation, interview and document review, the facility failed to ensure medications to manage resident behavior were not used unless necessary for 2 of 5 residents (R29 and R6) in the sample reviewed for unnecessary medications who utilized PRN (as needed) psychoactive medications to manage behaviors. Findings include: R29's quarterly Minimum Data Set (MDS) dated 11/20/15, indicated R29 had diagnoses including: dementia without behavioral disturbances, anxiety disorder and major depression. The MDS further indicated R29 was moderately cognitively impaired and required extensive assistance from staff to perform activities of daily living (ADLs). The Care Area Assessment for Psychotropic Drug Use was triggered due to R29's diagnoses and use of antidepressant and anti-anxiety medications. Review of R29's current physician's orders, Medication Review Report dated 10/27/15, indicated R29 utilized amitriptyline HCL (an antidepressant) 50 milligrams (mg) 1 tablet by mouth at bedtime related to depressive disorder (the dosage had been decreased 4/9/15 from 75 mg), Ativan (an antianxiety) 0.5 mg 1 tablet by mouth three times a day related to anxiety (the dosage had been increased 1/7/13 from twice a day to three times a day), and Ativan 0.5 mg 1 tablet by mouth every 6 hours PRN for anxiety (initiated 1/7/14). During observation of R29 on 1/26/16 from 12:11 p.m. -7:30 p.m., and on 1/27/16 from 6:00 a.m.-10:30 a.m., R29 was observed in multiple social situations including group BINGO, meals,	F 329		

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F 329	Continued From page 11 and watching television in the community day room. R29 was not observed to display any signs or symptoms of anxiety. R29's care plan revised 9/10/14, indicated R29 used daily prescribed medications for diagnoses of depression and anxiety. The care plan identified target behaviors to include: isolating self, crying, anxiousness, inability to sleep, sudden increase in pain especially in knees, fixating, restless/wandering. The interventions included; administer medications as ordered by physician, and monitor for side effects and effectiveness. In review of the facility's care sheet system (Kardex Report - undated) used by the direct care staff, documented in the "Behavior/Mood" section directed the staff to monitor and record the same behaviors as outlined in R29's care plan. During interview with the social work designee (SWD) on 1/27/16 at 12:10 p.m., the SWD stated R29 has major depression and anxiety issues and has a very supportive family locally. However, the SWD stated there were times when R29 had telephone conversations with others when she was observed to have increased anxiety. The SWD further stated she was working closely with those close to R29 to help manage the anxiety issue. She added that R29 has the right to communicate with who she chooses, and has not requested facility staff to limit telephone conversations with those who cause her anxiety. The facility utilized a data collection tool so staff could monitor on each shift any behavioral occurrences, use of PRN medications, and whether there were any medication side effects.	F 329		

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F 329	Continued From page 12 In review of the progress notes for R29's behavior, it was noted that both the progress notes and the behavior monitoring tool verified the administration of PRN ativan on the following dates: - On 1/10/16 at 02:02 a.m. - "Note Text: Ativan Tablet 0.5 MG Give 0.5 mg by mouth every 6 hours as needed for anxiety related to ANXIETY DISORDER, UNSPECIFIED (F41.9) res has been awake all this shift thus far. She has been restless and just worried about everything she stated and can't get to sleep Res req ativan to help her calm down relax so she can get to sleep. Above med admin as ordered." - On 12/12/15 at 4:31 p.m. - Note Text: Ativan Tablet 0.5 MG Give 0.5 mg by mouth every 6 hours as needed for anxiety related to ANXIETY DISORDER, UNSPECIFIED (F41.9) given per Leah's request for feelings of anxiousness/anxiety - On 12/9/15 at 11:57 p.m. - "Note Text: Up watching TV and is now anxious Ativan requested..." Even though the behavior monitoring tool used to review R29's anxiety state matched ativan doses given, there was no assessment indicated of non-pharmacological interventions having been attempted prior to the administration of the PRN doses of Ativan. During interview on 1/27/2016 at 11:49 a.m., nursing assistants (NA)-A and NA-B stated that they was to watch for the anxiety behaviors listed	F 329		

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F 329	Continued From page 13	F 329		

from nursing assessment. Both NAs stated that when they see behavior occurring, staff calmly visit with R29, off her coffee or a snack, offer toileting and/to lay down. However, both NAs stated that when they documented an observed behavior, the computer system only allows them to mark the behavior observed and not the non-pharmacological interventions provided.

During interview on 1/27/2016 at 11:56 a.m., licensed practical nurse (LPN)-A stated that the staff have been educated on non-pharmacological intervention, however with the current computer system, they do not have the ability to do so. LPN-A did stated that when a nurse administers a PRN medication, they should write a progress note in that resident's chart, describing the behavior, and what staff tried to do before administering a PRN medication.

In interview with the director of nursing (DON) on 1/28/2016, at 11:36 a.m. the director of nursing (DON) stated that the nurses appear not to be assessing and documenting the failed interventions prior to administering the Ativan to R29. The DON further stated that the facility used to document on a paper flow sheet what interventions were attempted prior to the administration of as needed medications and it was not carried over when the facility switched over to and electronic medical record. The DON stated her expectations were that the nurses are to assess the interventions tried and document them prior to administrating as needed medications.

In review of the facility's policy, entitled Unnecessary Drug Use Policy (last dated 2/13/13), Procedure 8 indicated the following: "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING _____ B. WING _____	01/28/2016

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

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F 329	Continued From page 14 The facility will perform a psychoactive medication assessment for mood / behavior which will include frequency, intensity of behavior and effectiveness of non-pharmacological interventions. Facility will review quarterly and PRN all psychoactive medications and monitor target behaviors monthly....Alternative interventions must be attempted before any PRN psychoactive medications are administered." R1's significant change Minimum Data Set (MDS) dated 11/17/15, included R1 had diagnoses of Alzheimer's disease, anxiety disorder and experienced delusions (misconceptions or beliefs that are firmly held contrary to reality.) R1's care plan dated 11/19/15, indicated R1 used psychoactive (affecting the mind) medications related to anxiety along with her delusional thoughts and hallucinations as well as R1 having a behavior problem of yelling out and being aggressive by hitting, swearing and refusing cares. The care plan identified target behaviors of hallucinations of thinking people are in bed with her and delusional thoughts of people talking to her that are not there. The care plan also indicated R1 see's people that are not present along with refusing cares and yelling at others. The care plan directed staff to administer medications as ordered by the physician and monitor/document side effects and effectiveness every shift, explain all procedures before starting and allow R1 to adjust to changes, and anticipate her needs. The undated Kardex Report directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. The Kardex further directed staff to intervene as necessary to	F 329		

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F 329	Continued From page 15	F 329		

protect the rights and safety of others and to approach R1 in a calm manner. In addition, the Kardex directed staff to remove R1 from situations and to take her to an alternate location and divert her attention.

Review of R1's Medication Review Report dated 1/20/16, signed by R1's physician and included diagnoses of hallucinations anxiety disorder and Alzheimer's disease. The Medication Review report included orders for haloperidol (medication used to treat hallucinations) 0.5 milligrams (mg) by mouth (po) every four hours PRN for agitation related to hallucinations.

Review of the November 2015 electronic medication administration record (EMAR) indicated R1 had received four doses of haloperidol 0.5 mg on 11/5/15, 11/11/15, 11/16/15 and 11/22/15. The EMAR indicated the dose was effective however, the medical record did not indicate an assessment of non-pharmalogical interventions and whether or not they were effective prior to the administration of the medication.

Review of the December 2015 EMAR indicated R1 had received four doses of haloperidol 0.5 mg on 12/20/15, 12/25/15, 12/28/15, and 12/31/15. The EMAR indicated the dose administered on 12/20/15 was ineffective and the other three doses were effective however, the medical record did not indicate an assessment of non-pharmalogical interventions prior to the administration of the PRN medication.

Review of the January 2016 EMAR indicated R1 had received five doses of haloperidol 0.5 mg on 1/5/16, 1/8/16, 1/13/16, 1/17/16, and 1/26/16. The

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F 329	Continued From page 16 EMAR indicated the dose was effective however the medical record did not indicate an assessment of non- pharmalogical interventions were ineffective prior to the administration of the medication. On 1/26/16, at 1:12 p.m. R1 was observed sitting in a recliner in the day room with her feet elevated. R1 removed her nasal cannula and was playing with it, pulling on the tubing and stretching. A nursing assistant approached R1 at 1:16 p.m. and asked R1 if she could place her nasal cannula back into place. R1 nodded yes and the nursing assistant placed the nasal cannula into her nostrils. Not sure if this is needed, this was the closest observation I had R/T a behavior, and I don't think it really supports the deficiency. When interviewed on 1/28/16, at 10:13 a.m. licensed practical nurse (LPN)- A stated that the aids and nurses are intervening with non-pharmalogical interventions prior to the administration of haloperidol for R1 however, the nurses are not documenting what interventions were attempted and the effectiveness of the interventions prior to administering the medication. LPN-A further stated that the facility had switched from paper charting to electronic charting with in the last year and did not add that component to the the electronic medical. When interviewed on 1/28/2016, at 11:36 a.m. the director of nursing (DON) stated the nurses were not assessing and documenting the failed interventions prior to administering the haloperidol to R1. The DON further stated that the facility used to document on a paper flow sheet what interventions were attempted prior to	F 329		

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F 329	Continued From page 17 the administration of as needed medications and it was not carried over when the facility switched over to and electronic medical record. The DON stated her expectations were that the nurses are to assess the interventions tried and document them prior to administrating as needed medications.	F 329		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	See Attached	3-4-16

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F 441	Continued From page 18 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement an infection control program which included surveillance, investigation of infections and analysis of data, to reduce and/or prevent the spread of infection. This had the potential to affect all 30 residents residing in the facility. Findings include: The facility's Infection Control Logs from October to December 2015, were reviewed. Information on the tracking logs included: Total number of infections, Skin, UTI (urinary tract infection), URI (upper respiratory infection), EYE, OTHER: Resident, Room number, Onset, Type of infection, S/S (signs and symptoms) infection, Culture, Organism, Antibiotic, Isolated, and date infection resolved. The October 2015 Infection Control Log identified five residents with infections. Two residents with UTI's, two residents with URIs, and one resident with chronic obstructive pulmonary disease (COPD) exacerbation. (COPD is a disease with constriction of the airways and difficulty or discomfort in breathing.) The infection data did not consistently identify resident room numbers,	F 441		

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F 441	Continued From page 19 documentation of onset/resolution, or any applicable cultures obtained to determine which organism(s) was identified. In addition, the information did not identify analysis of the collected data to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address prevention, or whether education was needed for staff and/or residents. The November 2015 Infection Control Log identified four residents with infections. Three residents had UTI's and one resident had cellulitis. (Cellulitis is a bacterial infection underneath the skin surface characterized by redness, warmth, swelling, and pain.) The infection data did not consistently identify resident room numbers, documentation of onset/resolution, or any applicable cultures obtained to determine which organism(s) was identified. The attached summary identified that two of the three residents with UTI's were dependent on staff for toileting. The other resident with a UTI was identified as having urinary retention (a condition when the bladder does not empty completely) and required straight catheterization (a process where a sterile catheter is used to remove urine from a person's bladder) several times a day. Although the above were identified as possible contributing factors to the infections, the summary did not identify ways to reduce the risk to other residents, action plans to address preventing the same infections in the facility, and whether education was needed for staff and/or residents. The December 2015 Infection Control Log identified six residents with seven infections.	F 441		

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F 441	Continued From page 20 There were three residents with UTI's (one had two UTIs in December), two residents with cellulitis, and one resident with an URI. The resident identified as having two UTIs was identified as having had an antibiotic change, with resolved UTI, however on the infection control log the date of antibiotic treatment initiation with type of antibiotic is not documented, so it is difficult to clearly identify the course of the infection and treatment. The infection data did not consistently identify applicable cultures obtained to determine which organism was identified, or documentation of resolution of symptoms. Further, there was no data analysis to determine possible causes of the infections, ways to reduce the risk of transmission to other residents, action plans to address preventing the same infections in the facility, or whether education was needed for staff and/or residents. During interview on 1/27/16, at 2:37 p.m., the director of nursing (DON), who is in charge of the facility infection control program , stated that she is aware that there is a problem with tracking resolution of symptoms of infections. The DON stated licensed nurses administer all antibiotics and enter in the information on the infection control log. This was initiated so licensed staff would observe infections, the effectiveness of the of treatment, and provide follow up as needed with the provider. The DON stated she reviews this information to see whether there is any correlations between the location of residents rooms in comparison to the illness of others (i.e., same wing, same room, etc.). The DON further stated the infection control log information, including review of monthly summary, is provided with other logs, including falls, emergency room visits, other accidents, pressure sores, and med	F 441		

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F 441	Continued From page 21 errors, and is reviewed at the Quality Assurance (QA) meetings quarterly. The DON stated that if an increased frequency of illness or infection was noted then a formalized training would be developed. The DON stated that good handwashing is stressed along with good infection control techniques. The facility policy, Infection Control Program dated 2010, outlined the importance of surveillance and monitoring as denoted under "Infection Control Professional: Responsibility, Qualifications, and Functions, on page 1.10, Section V, 2 a.) Review microbiology culture and sensitivity reports on a regular basis to identify types of organisms causing infections, monitor for antibiotic resistant organisms, and identify for potential resistant organisms between residents. b.) Perform surveillance for infections, compile and analyze data, prepare and bring reports to the Infection Control oversight committee. c.) Plan and participate in process improvement activities as needed and indicated by data analysis...f.) Monitor antibiotic use to help determine if appropriate." The facility did not identify whether infections were healthcare associated infection (HAI), an infection caused by any pathogen acquired as a consequence of being in the healthcare system; or community associated infections (CAI), contracted outside of a health care setting or present on admission.	F 441		

F Tag 156

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

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Resident R18 is no longer at this facility.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents, Director of Nursing will ensure that all medicare non coverage forms are filled out completely and timely. Social Service Designee will review and monitor follow through of completion of forms.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy on Medicare Denial Letters Procedure has been reviewed and/or revised. Case Manager, as assistant to Director of Nursing, will be retrained on this policy and procedure to maintain compliance . Interdisciplinary team will also retrained.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the	Audits of medicare denial notices will be conducted by Social Service weekly for four weeks and then randomly monthly for three months to ensure compliance with results reported to the QA/QI Committee for review and further recommendations.

corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	Social Service Designee will be responsible for compliance. Date of Completion: March 4, 2016

F Tag 314

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

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R23, a comprehensive assessment for a current pressure ulcer was completed, the family was updated and the primary MD was updated.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents, a weekly skin audit is completed by a licensed nurse to monitor for any changes in skin condition. Direct care staff will notify the charge nurse if they see a change in skin condition during cares. When a wound is identified, a comprehensive wound assessment will be completed including site, state, appearance of wound bed, any undermining, depth, drainage and status of peri-wound tissue. The nurse will initiate weekly wound monitoring, fax the primary MD for treatment direction, and notify the family. Case Manager will bring the information to weekly interdisciplinary team meeting once a week to identify any need for additional intervention that could enhance and speed up the healing process.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	Licensed nurses will be retrained on this policy and procedure to maintain compliance. This training was completed on 2/9/16. The policy for Skin/Pressure Ulcer Policy was reviewed and revised.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the	Audits of no less than three (3) skin audits being completed weekly will be done by designated staff each week for four (4) weeks and then randomly monthly for three (3) months to ensure compliance with results reported to the QA/QI committee for review and further recommendations.

corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 3/4/2016.

F Tag 329 Unnecessary Drugs

It is the policy of Wood Dale Home that each resident's drug regimen is free from unnecessary drugs.

An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. 2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that: (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R29 and R6 the non pharmacological intervention paper form that had been previously utilized before Point Click Care was reinstated for documentation of interventions being done prior to administration of the PRN medication. Non pharmacological interventions had been done but had not been documented.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents who may be affected by this practice, the non pharmacological interventions will be tried and documented prior to the administration of any PRN medication.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for unnecessary medications was reviewed and revised on 2/15/2016. Licensed staff were trained as it relates to their respective roles and responsibilities regarding the policy and procedure for unnecessary medications.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is	Unnecessary medication audits will completed weekly for four weeks, and then randomly monthly for three months, utilizing the MDS and Care Conference quarterly schedule to ensure continued compliance. The results will be reported to the QA/QI Committee for review and further recommendation.

integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 3/4/2016.

F Tag 441 Infection Control, Prevent Spread, Linens

It is the policy of Wood Dale Home to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

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

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

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Facility Infection Control Surveillance Log does/will include room numbers of the residents, onset date, type of infection, signs and symptoms of infection, culture, organism, antibiotic, isolated, and date resolved. The Infection Control Designee/Director of Nursing will complete an analysis of the data to reduce and prevent spread of infection, possible causes of infection, education needs for staff or resident, and identify if the infections are health care associated or community associated.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	The above policy and procedure is in place for residents of Wood Dale Home. Infection Control summaries are reviewed quarterly by QAA committee including Medical Director and Consulting Pharmacist.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice	The policy and procedure for Infection Control Surveillance was reviewed and revised on 02/22/2016. Licensed staff were trained on gathering data and completion of Infection Control Log.

does not recur?	
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Infection Control Log audits will be completed and reviewed weekly at interdisciplinary meeting for three months. Results will be reported to the QA/QI Committee for review and further recommendations.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 03/04/2016

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

F5261025

PRINTED: 02/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/27/2016

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

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

APPROVED
By Tom Linhoff at 11:00 am, Feb 24, 2016

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 10, 2014. 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

RECEIVED
FEB 23 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Ackerman	ADMINISTRATOR	2-22-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245261	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/27/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Wood Dale Home Incorporated is a one-story building with no basement. It was constructed in 1976, is fully fire sprinkler protected and was determined to be of Type II(222) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has single-station, battery operated smoke alarms in all Resident Rooms. The facility has a licensed capacity of 40 beds and had a census of 29 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT met by evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 8 of 29 residents, visitors, and staff members of the facility.	K 017		

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K 017	Continued From page 3 Findings include: On facility tour between 1:30 PM to 4:30 PM on 1/27/2016, observations revealed, that there was a 1 inch diameter hole by the sprinkler head that is in the corridor located next to resident room 310. This deficient condition was verified by a Maintenance Supervisor.	K 017		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 29 of 29 residents. Findings include:	K 050		

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K 050	Continued From page 4 On facility tour between 1:30 PM to 4:30 PM on 1/27/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had all of the overnight fire drill documentation marked as an overnight drill but had a day shift time written on the report. This deficient practices was confirmed by the Maintenance Director.	K 050		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3 2.1. This deficient practice could affect 29 of 29 residents, visitors, and staff. Findings include: On facility tour between 1:30 PM to 4:30 PM on 1/27/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of	K 054		

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K 054	Continued From page 5 the required sensitivity testing of each smoke detector located throughout the facility. This deficient practices was confirmed by the Maintenance Supervisor.	K 054		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect 16 of 29 residents, visitors and staff of the facility.	K 056		

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K 056	Continued From page 6 Findings include: On facility tour between 1:30 PM to 4:30 PM on 1/27/2016, observations revealed the following deficient conditions affecting the facility's fire sprinkler system: 1: The facility did not have at least 2 spare sprinkler heads for every style and type of fire sprinkler heads that are being used throughout the facility. 2: The sprinkler head in the beauty shop that is open to the corridor has a quick response head and there are standard sprinkler heads located in the corridor. This deficient practices was confirmed by the Maintenance Supervisor.	K 056		

APPROVED
By Tom Linhoff at 11:00 am, Feb 24, 2016

Wood Dale Home, Inc.

K017

Ceiling tile in corridor next to resident room 310 has been replaced.

Other ceiling tiles in corridors next to resident rooms have been checked and replaced as necessary.

Environmental Director is responsible for correction and monitoring to prevent reoccurrence of this deficiency.

Date of Correction: March 4, 2016

K050

Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift. The planning and conducting of these drills is assigned to a competent person who is qualified to exercise leadership.

Environmental Director is responsible for correction and monitoring to prevent reoccurrence of this deficiency.

Date of Correction: March 4, 2016

K 054
Simplex Grinnel, the licensed contractor for the testing of the smoke detector system has been contacted. The contractor has reviewed the report and has found that the required sensitivity testing has been completed on the smoke, photo detectors on the fire alarm system.

Environmental Director is responsible for correction and monitoring to prevent reoccurrence of this deficiency.

Date of Correction: 3/04/2016

K056
Facility has contacted and contracted With Simplex Grinnell for:

1. Having at least 2 spare sprinkler heads for every style and type of fire sprinkler heads used in facility.
2. Replace sprinkler head in the beauty shop with a standard sprinkler head as is also located in the corridor.

Environmental Director is responsible for correction and monitoring to prevent reoccurrence of this deficiency.
Correction Date: 3/4/2016