Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator
West Wind
Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

RE: CCN: 245262
Cycle Start Date: July 30, 2025

Dear Administrator:

On July 30, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 30, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 30, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 30, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, West Wind Village will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
The date that each deficiency will be corrected.
An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

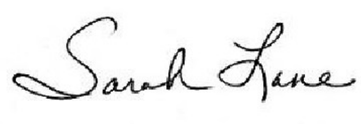
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Wind Village	1001 SCOTTS AVENUE , MORRIS, Minnesota, 56267

(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
E0000	Initial Comments On 7/28/25 to 7/30/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 7/28/25 to 7/30/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F0580		

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 reverse for further 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.

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

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F0580 SS = D	Continued from page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F0580		

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F0580 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the facility failed to notify the physician and resident representative for 1 of 1 resident (R7) who had a decline in range of motion (ROM) reviewed for limited ROM. R7's significant change Minimum Data Set (MDS) dated 6/6/25, identified R7 had moderate cognitive impairment and diagnosis which included cancer, hypertension (elevated blood pressure), and end stage renal disease (ESRD). R7 required moderate assist with activities of daily living (ADL's) which include bed mobility toileting and transfers and R7 had impairment on one side of upper extremity. R7's ADL Care Area Assessment (CAA) dated 6/18/25, identified R1 had physical limitations such as, limited range of motion , poor coordination, poor balance, visual impairment, or pain. R7 was at risk for complications of immobility such as contractures. R7's care plan revised 7/18/25 had a self-care deficit related to impaired balance and right sided upper extremity weakness. R7 was independent to walk with a walker. Care planned for PT/OT (physical/occupational therapies) to treat and eval as needed. Care plan lacked evidence of decreased ROM to right hand. During an observation on 7/29/25 at 5:48 p.m., R7 was walking from the dining room using a front wheeled walker. R7's right hand was down at her side and R7's fingers on her right hand were curled inward as R7 pushed her walker using only her left hand. R7 returned to her room and sat down in her recliner using only her left hand to touch the recliner as she sat down. During an observation on 7/30/25 at 8:42 a.m., R7 was walking from the dining room using a front wheeled walker. R7's right hand was down at her side and R7's fingers on her right hand were curled inward as R7 pushed her walker using only her left hand. R7 returned to her room and sat down in her recliner using only her left hand to touch the recliner as she sat down. During an observation and interview on 7/30/25 at 9:34 a.m., OT opened R7's fingers on the right hand and R7 yelled "ouch that hurts." OT did a full assessment of R7's right hand and stated R7 had significant contractures to the thumb and all four fingers on the right hand. OT stated when R7 was admitted to the facility six months ago there was only a little tightness in R7's right hand and no contractures. OT	F0580		

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F0580 SS = D	Continued from page 3 stated she had not been notified of R7's decline in ROM to the right hand. OT stated her expectation was staff would have notified her and the physician of R7's decline in ROM. During an interview on 7/30/25 at 10:13 a.m., NA-A stated R7 had some weakness in her right hand when she was admitted to the facility six months ago. NA-A stated up until two months ago R7 was able to fully open her right hand without pain. NA-A stated R7 has been complaining of pain in her right hand for the past 2 months. NA-A stated she had not told anyone about the decline in R7's ROM or complaints of pain because she assumed the nurses were aware. NA-A stated she was unaware of any limited ROM of R7's shoulder or forearm and did not think R7 had any functional maintenance programs. During an interview on 7/30/25 at 10:16 a.m., licensed practical nurse (LPN)-A stated R7 had some weakness in her right hand six months ago when she was admitted. LPN-A stated she had noticed R7 had a little more difficulty opening her right hand this past month but it did not appear much worse so she did not notify therapy R7 was having more difficulty opening her right hand. LPN-A stated someone should have let therapy know R7 was having more difficulty opening her right hand to prevent decreased ROM and contractures. During an interview on 7/30/25 at 10:20 a.m., R7 stated She was having more difficulty walking lately because she was unable to use her right hand. During an interview on 7/30/25 at 11:05 a.m., family member (FM)-A stated he has noticed the decreased ROM in R7's right hand in the past few months. FM-A stated he did not recall the facility notifying him of the decreased ROM in R7's right hand. During an interview on 7/31/25 at 12:20 p.m., director of nursing stated she thought R7 had contractures when she was admitted to the facility six months ago. DON stated she was unaware R7 had decreased ROM or developed contractures in her right hand in the past few months or if it had been reported. DON stated it was her expectation that any change in a resident's condition be reported to the nurse so it could be assessed. During an interview on 7/30/25 at 2:35 p.m., MD stated he does not recall being notified of R7's decline in ROM or contractures to her right hand. MD stated his expectation was that the facility would have let him know about R7's decline in ROM to prevent further	F0580		

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F0580 SS = D	Continued from page 4 decline in ROM and contractures from developing. Review of a facility policy titled Notification of Significant Changes revised 5/22/22, identified The Charge Nurse will immediately (as indicated by the change of condition) inform the resident, consult with the physician, and notify the resident representative (consistent with his or her authority), for the following significant change situations: A deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications.	F0580		
F0688 SS = G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess, implement and evaluate a loss in range of motion for 1 of 1 resident (R7) reviewed for range of motion. This practice resulted in harm when R7 was observed with her right hand contracted, increased pain and difficulty ambulating with a walker. In addition, the facility failed to provide functional maintenance programs as ordered to maintain and/or prevent loss of range of motion (ROM) for 8 of 8 residents (R7, R5, R3, R11,R17,R30,R33, R39) reviewed. Findings include:	F0688		

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F0688 SS = G	Continued from page 5 R7's significant change Minimum Data Set dated 6/6/25, identified R7 had moderate cognitive impairment and diagnosis of hypertension (elevated blood pressure), and end stage renal disease (ESRD) and required moderate assist with activities of daily living (ADL's) which include bed mobility toileting and transfers. R7 had impairment on one side of upper extremity. R7's ADL Care Area Assessment (CAA) dated 6/18/25, identified R1 had physical limitations such as, limited range of motion, poor coordination, poor balance, visual impairment, or pain. Identified R7 was at risk for complications of immobility such as contractures. R7's care plan revised 7/18/25, had a self-care deficit related to impaired balance and right (R) sided upper extremity weakness. R7 was independent to walk with a walker. Care plan identified PT/OT (physical/occupational therapies) to treat and evaluate as needed. R7's OT assessment dated 1/7/25, identified R7 had a functional impairment of the left shoulder and forearm and R7 had no functional impairment of the right shoulder and forearm. R7's OT discharge assessment dated 2/4/25, identified discharge recommendations to complete a functional maintenance (FMP) program of right shoulder and elbow 7 times per week. Assessment did not indicate any functional impairment of the right hand. R7's medical record lacked evidence the FMP program had been initiated after the 2/4/25 OT recommendations. R7's PT evaluation dated 3/21/25, identified Current Referral Reason R7 referred to PT due to staff wondering about a platform walker for her due to not using her R arm post CVA hx. R7 tends to rest her R hand on her walker vs holding onto it. Reason for Skilled Services: Skilled therapy necessary to assess need for platform walker and trial; however, she declines adamantly. R7 record lacked any further follow up or additional interventions related to her R hand. During two separate observations one on 7/29/25 at 5:48 p.m. and other on 7/30/25 at 8:42 a.m, R7 was pushing a front wheeled walker using her left hand with her right hand down at her side. R7's fingers on her right hand were curled inward. R7 returned to her room and sat down in her recliner using her left hand to touch the recliner as she sat down.	F0688		

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F0688 SS = G	Continued from page 6 During an observation and interview on 7/30/25 at 9:34 a.m., OT opened R7's fingers on the right hand and R7 yelled "ouch that hurts." OT did a full assessment of R7's right hand and stated R7 had significant contractures to the thumb and all four fingers on the right hand. OT stated when R7 was admitted to the facility six months ago R7 had mild tightness to her right hand and no contractures. OT stated R7 has had a significant decline in her ROM in her right hand since admission to the facility six months ago. R7's OT evaluation dated 7/30/25, identified R7 was referred to skilled OT due to decreased ROM of her fingers on the right hand, limiting her ability to participate in ADL's and functional mobility. R7 had redness on the tip of her thumb due to it being in between her 3rd and 4th fingers. Area does blanch when pressure is applied. R7 had pain while attempting to assess right hand and ROM. During an interview on 7/30/25 at 10:02 a.m., activities aide (AA)-A stated she had noticed in the past few months R7 was not able to open her right hand and the fingers on her right hand had curled in wards. AA-A stated she had not told anyone because she assumed the facility was aware of R7's decreased ROM and inability to open her right hand. During an interview on 7/30/25 at 10:10 a.m., nursing assistant (NA)-B stated R7's right hand was a little tight when R7 was admitted to the facility six months ago but in the past two months R7's ROM in her right hand has decreased and R7 no longer was able to open her right hand. NA-B did not think R7 had any functional maintenance programs. NA-B stated she did not tell anyone and stated she should have told the nurses about R7's decreased ROM in her right hand. During an interview on 7/30/25 at 10:13 a.m., NA-A stated R7 had some weakness in her right hand when she was admitted to the facility six months ago. NA-A stated up until two months ago R7 was able to fully open her right hand without pain. NA-A stated R7 has been complaining of pain in her right hand for the past 2 months and was no longer able to open her right hand. NA-A stated she had not told anyone about the decline in R7's ROM or complaints of pain because she assumed the nurses were aware. During an interview on 7/30/25 at 10:20 a.m., R7 stated she was having more difficulty walking lately because she was unable to use her right hand to push her walker.	F0688		

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F0688 SS = G	Continued from page 7 During an interview on 7/30/25 at 10:28 a.m., registered nurse (RN)-A stated her expectation was that staff would have let her know when R7's ROM in her right hand began to decrease so she could have let the medical doctor (MD) and therapy know to prevent further decreased ROM and contractures. During an interview on 7/30/25 at 11:05 a.m., family member (FM)-A stated three months ago R7 was able to open her right hand to use the FWW walker. FM-A stated in the past two months R7 had complained of pain in her right hand, was no longer able to open her right hand or able to use her right hand to push her walker. During an interview on 7/31/25 at 12:20 p.m., director of nursing (DON) verified R7 had contractures in her right hand . DON stated she was unaware R7 had decreased ROM or developed the contractures in her right hand in the past few months. DON stated it was her expectation any change in a resident's condition be reported to the nurse and the physician so it could be assessed to prevent a decline in ROM and contractures. During an interview on 7/30/25 at 2:35 p.m., medical doctor (MD) stated he did not recall being notified of R7's decline in ROM or contractures to her right hand. MD stated his expectation was the facility would have let him know about R7's decline in ROM to prevent further decline in ROM and prevent contractures from developing. R3 R3's annual Minimum Data Set (MDS) assessment dated 6/3/25, identified R3 was cognitively intact and was dependent on staff for all activities of daily living (ADLs). R3 had a diagnosis of hypertension (high blood pressure), diabetes, and hemiplegia (one-side weakness). R3's care area assessment (CAA) dated 5/29/25, indicated R3 was at risk for developing contractures and R3 had restricted mobility. R3's physical therapy (PT) orders signed 5/3/24, R3 was set up with a ROM/orthotic program. On 7/24/25, PT placed orders for R3 to stand one time a shift on day and night shift with platform walker, with the assist of two at the edge of the bed. PT orders lacked documentation on the length of time R3 was to stand with staff. R3's care plan dated 6/27/25, indicated R3 was to	F0688		

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F0688 SS = G	Continued from page 8 receive gentle range of motion (ROM) as tolerated with daily care. R3's care plan lacked information providing what extremity R3 was to have ROM completed on. R3's electronic treatment administration record (eTAR) dated 7/25, lacked documentation R3 was to receive ROM or stand at the edge of the bed with a platform walker and a assist of two. R3's progress notes dated 5/1/25 to 7/30/25, lacked documentation R3 was to receive gentle ROM as tolerated with daily cares. During an interview on 7/30/25 at 1:31 p.m., PT-A confirmed R3 was on a standing program with staff two to three times a day. PT-A indicated the orders were provided to nursing staff to enter the orders on R3's care plan. During an interview on 7/30/25 at 1:47 p.m., NA-E indicated NA-E was unaware R3 had orders to stand one time a shift on day and night shift with platform walker, with the assist of two at the edge of the bed. NA-E further indicated staff do not have time to complete ROM on residents daily. R5 R5's admission Minimum Data Set (MDS) assessment dated 6/3/25, identified R5 was severely cognitively impaired and needed moderate assistance with all activities of daily living (ADLs). R5 had a diagnosis of dementia, diabetes, and anxiety, R5's care area assessment (CAA) dated 5/26/25, indicated R5 was at risk for developing pressure ulcers. R5's care plan dated 6/14/25, indicated R5 required the assist of one with a walker and gait belt for ambulation. R5's physical therapy (PT) orders signed 5/14/25, R5 was to transfer with the assist of one with walker. R5's eTAR dated 7/25, lacked documentation R5 was being ambulated with the assist of one with walker and gait belt. R5's Kardex Report dated 7/30/25, indicated R5 required the assist of one with a walker and gait belt for ambulation. R5's progress notes dated 5/13/25 to 7/30/25, lacked	F0688		

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F0688 SS = G	Continued from page 9 documentation R5 was receiving the assistance of one with walker and gait belt for ambulation. R11 R11's quarterly Minimum Data Set (MDS) dated 4/28/25, identified R11 was severely cognitively impaired and was dependent on staff for all activities of daily living (ADLs). R11 had a diagnosis of dementia, hypertension (high blood pressure), and deep vein thrombosis (DVT) (blood clot). R11's care area assessment (CAA) dated 10/23/24, indicated R11 was at risk for pressure ulcers and pain due to body positioning. R11's care plan dated 3/10/25, indicated R11 was to receive passive range of motion (PROM) to all extremities. R11's care plan lacked information indicating how often staff were to perform PROM for R11. R11's physical therapy (PT) orders signed 9/26/24, identified R11 presented with impaired ROM and position of joints consistent with R11's level of dementia. R11 was a good candidate for set up of ROM program. R11's eTAR dated 7/25, lacked documentation R11 was receiving PROM. R11's Kardex Report dated 7/30/25, lacked documentation R11 was to receive PROM. R11's progress notes dated 5/1/25 to 7/30/25, lacked documentation R11 was receiving PROM. R30 R30's quarterly Minimum Data Set (MDS) assessment dated 4/29/25, identified R30 was cognitively intact and needed minimal assistance with all activities of daily living (ADLs). R30 had a diagnosis of hypertension (high blood pressure), dementia, and a traumatic brain injury (TBI) R30's care area assessment (CAA) dated 1/16/25, indicated R30 was at risk for loss of arm or leg movement and pressure ulcers. R30's care plan dated 1/14/25, indicated R30 was to receive PROM with the assist of one staff to the lower extremity. R30's care plan lacked information on what lower extremity was to receive PROM.	F0688		

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F0688 SS = G	Continued from page 10 R30's physical therapy (PT) orders signed 4/15/24, identified education was provided to nursing on completing ROM program. PT orders lacked information identifying what education was provided to nursing and where R30 was to be receiving ROM. R30's electronic treatment record (eTAR) dated 7/25, lacked documentation R30 was receiving ROM on R30's lower extremity. R30's Kardex Report dated 7/30/25, lacked documentation R30 was to receive ROM on R30's lower extremity. R30's progress notes dated 5/1/25 to 7/30/25, lacked documentation R30 was receiving ROM on R30's lower extremity. R33 R33's quarterly Minimum Data Set (MDS) assessment dated 5/20/25, identified R33 was severely cognitively impaired and dependent on staff with all activities of daily living (ADLs). R33 had Alzheimer's disease and depression. R33's care area assessment (CAA) dated 11/12/24, indicated R33 was at risk for pressure ulcers and pain. R33's care plan dated 4/28/25, indicated R33 was to receive lower extremity, upper extremity, and neck PROM exercises. R33's care plan lacked information identifying what lower and upper extremity was to receive PROM. R33's physical therapy (PT) orders signed 4/15/20, nursing staff ROM program has been implemented and staff educated. R33's electronic treatment record (eTAR) dated 7/25, lacked documentation R33 was receiving lower extremity, upper extremity, and neck PROM exercises. R33's progress notes dated 5/1/25 to 7/30/25, lacked documentation R3 was receiving lower extremity, upper extremity, and neck PROM exercises. During an interview on 7/30/25 at 12:46 p.m., NA -A revealed the facility no longer had a restorative aid. NA-A indicated there were several residents on a restorative program and staff were required to complete restorative therapy when assisting residents up in the morning. NA-A further indicated staff did not have enough time to complete all the needs of the residents which included restorative therapy.	F0688		

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F0688 SS = G	Continued from page 11 During an interview on 7/30/25 at 12:56 p.m., LPN-A stated NAs were responsible for completing restorative therapy on residents. LPN-A further stated the facility had not had a restorative program for about a year and a half. LPN-A indicated staff had never let her know if residents had refused restorative therapy, but she would expect them to let the nurse know. LPN-A further indicated if a resident refused it should have been documented in the residents' notes. During an interview on 7/30/25 at 1:03 p.m., OT-B stated NAs were trained on how to perform restorative therapy on residents with orders from PT/OT (physical/occupational therapy). OT-B further stated if staff did not know how to perform therapy, they would receive additional training and guidance from PT/OT. OT-B indicated all restorative therapy orders were written in the residents' care plans. During an email interview on 7/30/25 at 2:05 p.m., director of nursing (DON) indicated the ROM restorative therapy information is stored on the Kardex however, staff do not sign off that restorative therapy was completed. During an interview on 7/30/25 at 2:35 p.m., LPN-B stated R3s restorative therapy orders would have shown up on the NAs task list to be completed. LPN-B indicated NAs should have been letting nursing staff know if residents were refusing therapy. LPN-B further indicated LPN-B was unaware of any residents refusing therapy. During an interview on 7/30/2025 at 3:30 p.m., PT-B stated orders were put on a sheet and placed in a binder. PT-B further stated the binder used to be in the activities room, but PT-B did not know where the binder went. PT-B indicated the previous process changed when the new system took place and now the sheets are placed in the unit managers bin to be added to the care plans. During an interview on 7/30/25 at 5:15 p.m., DON confirmed the above findings and stated her expectations was staff were to be following the Kardex and care plan to get exercises completed. DON stated she was unaware why the restorative therapy orders were not linking to the tasks so staff could sign them off when they were completed. DON further stated it was important for residents to receive restorative therapy so there is not a decline in the residents or if a decline is noted the resident could be referred to PT/OT.	F0688		

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F0688 SS = G	Continued from page 12 R17 R17's quarterly Minimum Data Set (MDS) assessment dated 6/3/25, identified R17 as having severe impaired cognition. R17 needed extensive assistance for all activities of daily living (ADLs). R17 had a diagnosis of peripheral vascular disease (narrowing of the blood vessels), arthritis, and hypertension (high blood pressure). No restorative nursing programs was indicated on the MDS. R17's Care Area Assessment (CAA) dated 11/8/24, identified R17 had physical impairments such as weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. R17's signed occupational therapy orders dated 12/11/23, revealed occupational therapist (OT) ordered an restorative nursing program to help with carryover and consistency for left upper extremity ROM. Orders included left upper extremity passive range of motion/ active range of motion for elbow flex/extend, shoulder protraction/ retraction/ flex/extension, horizontal abduction/adduction, and wrist flex/extend to help increase flexibility for ADL/s five repetitions with each exercise. R17's care plan dated 10/23/24, indicated R17 was at risk for contractures related to left hemiparesis following a cerebrovascular accident (CVA). The goal was to maintain shoulder range of motion (ROM) by participating in ROM exercises. Nursing was to assist in passive ROM to the left upper extremity shoulder, elbow, and wrist flexion/ extension and abduction/ adduction, all 10 repetitions, two sets. Cue R17 to rest and relax between sets. Three to five times a week, as R17 would allow. R17's medical record under the tasks lacked a restorative program. During an interview on 7/30/25 at 9:13 a.m., licensed practical nurse (LPN)-A indicated that the nursing assistants performed restorative programs, which include ROM. During an observation on 7/30/25 at 9:25 a.m., R17 was sitting in the dining room with left elbow and hand on a padded wheelchair armrest. During an interview on 7/30/25 at 10:42 a.m., occupational therapist (OT)-A indicated that on 12/11/23, OT set up a restorative program for R17.	F0688		

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F0688 SS = G	Continued from page 13 During an interview on 7/30/25 at 1:20 p.m., physical therapist (PT)-B indicated that on 12/11/23, OT set up a ROM program for staff to complete and it was not discontinued. R39 R39's quarterly Minimum Data Set (MDS) assessment dated 7/1/25, identified R39 was severely cognitively impaired and needed extensive assistance with all activities of daily living (ADLs). R39 had a diagnosis of Lewy bodies (affects cognitive and motor functions), Parkinson's (movement disorder), and hypertension (high blood pressure). No restorative nursing programs was indicated on the MDS. R39's CAA dated 12/5/24, identified R39 had assistance with eating, needed assistance with toileting. R39 had cognitive impairment, dementia, and neuromuscular functional risk factors. R39's signed occupational therapy orders dated 6/24/24 indicated R39 would continue to need ROM assistance to help improve ROM. R39 was unable to complete ROM on her own; nursing staff were educated on how to provide ROM for R39. On 6/19/24, the staff received an education sheet on how to complete ROM exercises and indicated ROM was to be done once in the morning and once in the evening. The education sheet provides pictures on how to perform elbow, forearm, shoulder, and wrist ROM. R39's care plan dated 10/24/24, indicated R39 had a passive ROM program to the upper and lower extremities, three times a week as able. R39's medical record under the tasks lacked a restorative program. During an interview on 7/30/25 at 10:42 a.m., occupational therapist OT-A indicated that OT would ask nursing staff quarterly if there were any changes with residents. Nursing staff had not discussed any changes to OT regarding R39. OT-A indicated on 6/24/24, R39 was placed on a ROM program for the elbow and hand for the nursing staff to complete. During an interview on 7/30/25 at 1:08 p.m., physical therapist (PT)-A indicated that on 6/19/24, R39 received orders to continue the restorative program. PT-A confirmed the ROM was not discontinued and would expect staff to continue as R39 tolerated.	F0688		

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F0688 SS = G	Continued from page 14 During an interview on 7/30/25 at 1:44 p.m., NA-A indicated residents participating in a restorative program had a spot in the tasks section on the computer to alert staff of their participation in the restorative program. NA-A viewed the task section for R17 and R39 and indicated that R17 and R39 lacked documentation of a restorative program needed to be performed. During an interview on 7/30/25 at 1:45 p.m., nursing assistant (NA)-B indicated there was no restorative aid in the facility, and the nursing assistants were responsible for performing ROM on residents who had a restorative program. If a resident had a restorative program, the computer would show this in a task section. NA-B indicated R17 and R39 did not have a restorative program, as there was no information in the task section of the computer's Kardex, which the nursing assistants used to identify who had a restorative program. During an interview on 7/30/25 at 3:30 p.m., registered nurse (RN)-A indicated the process was for OT to place restorative orders in a box by the nurse station. RN-A would take the orders and place them in the care plan, then give a copy of the orders to the staff. The facility received a new computer system this past year, and when the restorative program is placed into the care plan, it would populate on the nursing assistant's Kardex tasks on the computer. RN-A indicated that no issues were reported altering staff the Kardex task did not pull from the care plan. The facility policy titled Restorative Nursing Program, dated 4/6/20, identified the facility will have a restorative nursing program that promotes a resident's ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care. Procedure: Residents will be evaluated on admission, ongoing and at least quarterly to determine the need for restorative nursing services by the Restorative Coordinator or nursing-designed and/or contracted therapy. The Restorative Coordinator or designee will inquire as to the resident’s interest in participating with the recommended restorative nursing services, if applicable. If the resident declines/refuses recommended restorative A nursing services, an Informed Choice Consent form will be completed with the resident and/or resident representative regarding the risks and benefits of the services recommended by the Restorative Coordinator or designee and/or Contracted Therapy. The Restorative Nursing Coordinator or nursing designee will develop	F0688		

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F0688 SS = G	Continued from page 15 the program(s), in collaboration with Therapy if the program is recommended by Therapy, for residents who are identified as having the potential to benefit from the program(s). The Restorative Nursing Coordinator or nursing designee will develop the program(s), in collaboration with Therapy if the program is recommended by Therapy, for residents who are identified as having the potential to benefit from the program(s). A Restorative Assessment will be completed by the RN Restorative Coordinator or by nursing staff under the supervision of the RNC. This will include identifying and care planning the residents' need for restorative nursing services, goal(s), and interventions to meet the goal(s). When a resident is started on a RNP or has a change to their current RNP, the Restorative Coordinator or designee will communicate these changes with the resident, the nursing department and any staff who provide restorative nursing services. Restorative Coordinator or designee will keep the nursing leadership team and providers informed of resident's progress in regard to restorative nursing services, as needed. Restorative Coordinator or designee (must be a registered nurse) and/or Contracted Therapy will train the restorative staff on restorative techniques and individual restorative Nursing program(s). Restorative staff will show competency in restorative nursing programs. Training will be completed on an ongoing basis, as needed. Restorative staff will be responsible for providing the residents with restorative nursing services and will document completion. If a resident is refusing restorative nursing services or has had a change in condition/function, the restorative staff will report to the Restorative Coordinator or designee and the Nurse Supervisor in a timely manner. Documentation of non-compliance will include reason for refusal and any intervention(s) to promote compliance. If resident continues refusal of RNP after implementing interventions and education to promote compliance, the Restorative Coordinator or designee may complete an Informed Choice Consent form with the resident and/or resident representative. The Restorative Coordinator or designee will ensure documentation of the restorative program is complete. Restorative Coordinator or designee will meet with staff performing restorative services routinely to review programs, review documentation, and make recommendations in regard to restorative nursing services. Restorative Coordinator or designee (Registered Nurse) will evaluate the resident's restorative nursing program at least quarterly and document the evaluation in the electronic health record. The evaluation will include the resident's progress toward the goal, any barriers that interfere with the resident's progress, interventions	F0688		

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F0688 SS = G	Continued from page 16 attempted to assist the resident to overcome the barriers, an assessment of frequent refusals to participate in the restorative program and the rationale for the decision to revise, continue or discontinue the restorative nursing program. Restorative Coordinator or designee will update the restorative care plan, as needed. Restorative Coordinator or designee will monitor on an ongoing basis all aspects of the individualized restorative programs being offered. Audits will be completed as needed to review and identify any trends with the restorative nursing program. The Restorative Coordinator or designee will participate and develop a report for Quarterly QAPI meetings. These reports will help identify any variations and gaps to refer for review, improvement and increased monitoring.	F0688		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to re-assess and develop interventions for residents at risk for elopement (leave the facility without staff knowledge) for 1 of 3 residents (R1) reviewed for elopement. Findings include: R7’s significant change Minimum Data Set assessment dated 6/6/25, identified R7 had moderate cognitive impairment and diagnosis which included cancer, hypertension (elevated blood pressure), and end stage renal disease (ESRD). R7 required moderate assist with activities of daily living (ADL’s) which include bed mobility toileting and transfers and had impairment on one side of upper extremity. R7's care plan revised 7/28/25, identified R7 was at risk for wandering and had a wander guard on.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Wind Village	1001 SCOTTS AVENUE , MORRIS, Minnesota, 56267

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F0689 SS = D	Continued from page 17 Interventions included: provide care in a calm and reassuring manner. Care plan lacked further interventions related to wandering. R7's elopement risk assessment dated 6/6/25, identified R7 had no desire to leave, requests assistance to get into and out of the building due to vision. R7 would be able to sit outside independently with use of a call light for assistance to get back in. R7 was not at risk to wander or elope. R7's progress note dated 7/25/25 at 3:25 p.m., identified R7 went out the back door unattended. A family member of another resident reported R7 was in the parking lot to facility staff. Staff went to the parking lot and escorted R7 back into the building. R7's family was notified and a wander guard was placed on R7. R7 was angry. R7's medical record lacked evidence of any follow-up elopement assessment. During an observation on 7/29/25 at 10:37 a.m., R7 was seated in her room in her recliner with a wander guard on her left wrist. During an interview on 7/29/25 at 12:33 p.m., nursing assistant (NA)-C stated she was very familiar with R7. NA-C stated as far as she knew R7 had no history of wandering and has never gone outside without staff. NA-C further stated did not think R7 had a wander guard and was unaware of any care planned interventions for R7 related to wandering. During an interview on 7/29/25 at 12:36 p.m., NA-D stated R7 went outside a few days ago without staff. NA-D stated R7 talks a lot about wanting to go sit outside. NA-D stated she was unaware how often staff took R7 to sit outside. NA-D stated the only care planned intervention for R7 after going outside without staff was a wander guard. During an interview on 7/29/25 at 12:41 p.m., licensed practical nurse (LPN)-A stated R7 attempted to elope from the facility a few days ago. LPN-A stated a wander guard was placed on R7 after she attempted to elope from the facility. LPN-A stated there were no further care planned interventions for R7 related to wandering. During an interview on 6/30/25 at 10:28 a.m., nurse manager (NM)-A stated she was aware R7 had gone outside the facility a few days ago. NM stated she was unsure why R7 went outside. NM stated a wander guard was placed on R7 and no further elopement assessments had	F0689		

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F0689 SS = D	Continued from page 18 been done for R7. NM further stated she was unaware of any further care planned interventions for R7 related to wandering. NM stated her expectation was a new elopement risk assessment would have been done and more care planned interventions would have been implemented for R7 related to wandering. During an interview on 7/29/25 at 4:38 p.m., director of nursing (DON) verified R7 had eloped over the weekend and was at risk for further elopements. DON stated R7 stated she just wanted to go sit outside. DON verified a new elopement assessment had not been completed for R7 after the elopement and the only care planned intervention was a wander guard had been placed on R7. DON stated her expectation was a new elopement risk assessment would have been done and more care planned interventions would have been implemented for R7 related to wandering. Facility policy titled Elopement dated 8/1/22, identified, If it was unknown by the care center staff that the resident had left the building and is found outside by staff or visitor, this incident would constitute an ‘elopement’ and would require a report to the state agency. When the resident who eloped is located the facility would have conducted an investigation to determine how the elopement occurred in order to correct any underlying contributing factors.	F0689		

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/28/25 to 7/30/25, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		

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

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical,	20265		

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20265	Continued from page 2 mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the facility failed to notify the physician and resident representative for 1 of 1 resident (R7) who had a decline in range of motion (ROM) reviewed for limited ROM. Findings include: R7's significant change Minimum Data Set (MDS) dated 6/6/25, identified R7 had moderate cognitive impairment and diagnosis which included cancer, hypertension (elevated blood pressure), and end stage renal disease (ESRD). R7 required moderate assist with activities of daily living (ADL's) which include bed mobility toileting and transfers and R7 had impairment on one side of upper extremity. R7's ADL Care Area Assessment (CAA) dated 6/18/25, identified R1 had physical limitations such as, limited range of motion , poor coordination, poor balance, visual impairment, or pain. R7 was at risk for complications of immobility such as contractures. R7's care plan revised 7/18/25 had a self-care deficit related to impaired balance and right sided upper extremity weakness. R7 was independent to walk with a walker. Care planned for PT/OT (physical/occupational therapies) to treat and eval as needed. Care plan lacked evidence of decreased ROM to right hand. During an observation on 7/29/25 at 5:48 p.m., R7 was walking from the dining room using a front wheeled walker. R7's right hand was down at her side and R7's fingers on her right hand were curled inward as R7	20265		

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20265	Continued from page 3 pushed her walker using only her left hand. R7 returned to her room and sat down in her recliner using only her left hand to touch the recliner as she sat down. During an observation on 7/30/25 at 8:42 a.m., R7 was walking from the dining room using a front wheeled walker. R7's right hand was down at her side and R7's fingers on her right hand were curled inward as R7 pushed her walker using only her left hand. R7 returned to her room and sat down in her recliner using only her left hand to touch the recliner as she sat down. During an observation and interview on 7/30/25 at 9:34 a.m., OT opened R7's fingers on the right hand and R7 yelled "ouch that hurts." OT did a full assessment of R7's right hand and stated R7 had significant contractures to the thumb and all four fingers on the right hand. OT stated when R7 was admitted to the facility six months ago there was only a little tightness in R7's right hand and no contractures. OT stated she had not been notified of R7's decline in ROM to the right hand. OT stated her expectation was staff would have notified her and the physician of R7's decline in ROM. During an interview on 7/30/25 at 10:13 a.m., NA-A stated R7 had some weakness in her right hand when she was admitted to the facility six months ago. NA-A stated up until two months ago R7 was able to fully open her right hand without pain. NA-A stated R7 has been complaining of pain in her right hand for the past 2 months. NA-A stated she had not told anyone about the decline in R7's ROM or complaints of pain because she assumed the nurses were aware. NA-A stated she was unaware of any limited ROM of R7's shoulder or forearm and did not think R7 had any functional maintenance programs. During an interview on 7/30/25 at 10:16 a.m., licensed practical nurse (LPN)-A stated R7 had some weakness in her right hand six months ago when she was admitted. LPN-A stated she had noticed R7 had a little more difficulty opening her right hand this past month but it did not appear much worse so she did not notify therapy R7 was having more difficulty opening her right hand. LPN-A stated someone should have let therapy know R7 was having more difficulty opening her right hand to prevent decreased ROM and contractures. During an interview on 7/30/25 at 10:20 a.m., R7 stated She was having more difficulty walking lately because she was unable to use her right hand. During an interview on 7/30/25 at 11:05 a.m., family	20265		

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20265	Continued from page 4 member (FM)-A stated he has noticed the decreased ROM in R7's right hand in the past few months. FM-A stated he did not recall the facility notifying him of the decreased ROM in R7's right hand. During an interview on 7/31/25 at 12:20 p.m., director of nursing stated she thought R7 had contractures when she was admitted to the facility six months ago. DON stated she was unaware R7 had decreased ROM or developed contractures in her right hand in the past few months or if it had been reported. DON stated it was her expectation that any change in a resident's condition be reported to the nurse so it could be assessed. During an interview on 7/30/25 at 2:35 p.m., MD stated he does not recall being notified of R7's decline in ROM or contractures to her right hand. MD stated his expectation was that the facility would have let him know about R7's decline in ROM to prevent further decline in ROM and contractures from developing. Review of a facility policy titled Notification of Significant Changes revised 5/22/22, identified The Charge Nurse will immediately (as indicated by the change of condition) inform the resident, consult with the physician, and notify the resident representative (consistent with his or her authority), for the following significant change situations: A deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications SUGGESTED METHOD OF CORRECTION: The facility should create policies or review and/or revise existing policies and procedures related to notification of change in resident range of motion status or a change of condition. The Director of Nursing (or designee) should educate or re-educate nursing staff to those policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1	20830		

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20830	Continued from page 5 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to re-assess and develop interventions for residents at risk for elopement (leave the facility without staff knowledge) for 1 of 3 residents (R1) reviewed for elopement. Findings include: R7’s significant change Minimum Data Set assessment dated 6/6/25, identified R7 had moderate cognitive impairment and diagnosis which included cancer, hypertension (elevated blood pressure), and end stage renal disease (ESRD). R7 required moderate assist with activities of daily living (ADL’s) which include bed mobility toileting and transfers and had impairment on one side of upper extremity. R7's care plan revised 7/28/25, identified R7 was at risk for wandering and had a wander guard on. Interventions included: provide care in a calm and reassuring manner. Care plan lacked further interventions related to wandering. R7's elopement risk assessment dated 6/6/25, identified R7 had no desire to leave, requests assistance to get into and out of the building due to vision. R7 would be able to sit outside independently with use of a call light for assistance to get back in. R7 was not at risk to wander or elope. R7’s progress note dated 7/25/25 at 3:25 p.m., identified R7 went out the back door unattended. A family member of another resident reported R7 was in the parking lot to facility staff. Staff went to the parking lot and escorted R7 back into the building. R7's family was notified and a wander guard was placed on R7. R7 was angry. R7's medical record lacked evidence of any follow-up elopement assessment.	20830		

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20830	Continued from page 6 During an observation on 7/29/25 at 10:37 a.m., R7 was seated in her room in her recliner with a wander guard on her left wrist. During an interview on 7/29/25 at 12:33 p.m., nursing assistant (NA)-C stated she was very familiar with R7. NA-C stated as far as she knew R7 had no history of wandering and has never gone outside without staff. NA-C further stated did not think R7 had a wander guard and was unaware of any care planned interventions for R7 related to wandering. During an interview on 7/29/25 at 12:36 p.m., NA-D stated R7 went outside a few days ago without staff. NA-D stated R7 talks a lot about wanting to go sit outside. NA-D stated she was unaware how often staff took R7 to sit outside. NA-D stated the only care planned intervention for R7 after going outside without staff was a wander guard. During an interview on 7/29/25 at 12:41 p.m., licensed practical nurse (LPN)-A stated R7 attempted to elope from the facility a few days ago. LPN-A stated a wander guard was placed on R7 after she attempted to elope from the facility. LPN-A stated there were no further care planned interventions for R7 related to wandering. During an interview on 6/30/25 at 10:28 a.m., nurse manager (NM)-A stated she was aware R7 had gone outside the facility a few days ago. NM stated she was unsure why R7 went outside. NM stated a wander guard was placed on R7 and no further elopement assessments had been done for R7. NM further stated she was unaware of any further care planned interventions for R7 related to wandering. NM stated her expectation was a new elopement risk assessment would have been done and more care planned interventions would have been implemented for R7 related to wandering. During an interview on 7/29/25 at 4:38 p.m., director of nursing (DON) verified R7 had eloped over the weekend and was at risk for further elopements. DON stated R7 stated she just wanted to go sit outside. DON verified a new elopement assessment had not been completed for R7 after the elopement and the only care planned intervention was a wander guard had been placed on R7. DON stated her expectation was a new elopement risk assessment would have been done and more care planned interventions would have been implemented for R7 related to wandering. Facility policy titled Elopement dated 8/1/22, identified, If it was unknown by the care center staff	20830		

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20830	Continued from page 7 that the resident had left the building and is found outside by staff or visitor, this incident would constitute an ‘elopement’ and would require a report to the state agency. When the resident who eloped is located the facility would have conducted an investigation to determine how the elopement occurred in order to correct any underlying contributing factors. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analysis of residents at risk of elopement. The DON or designee should educate staff and conduct measurable audits of wandering residents. To ensure analysis of the root cause is completed, and ensure identified interventions are in place to prevent elopement. The DON or designee should ensure the results of those audits are taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	20830		
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess, implement and evaluate a loss in range of motion for 1 of 1 resident (R7) reviewed for range of motion. This practice resulted in harm when R7 was observed with her right hand contracted, increased pain and difficulty ambulating with a walker. In addition, the facility failed to provide functional maintenance programs as ordered to maintain and/or prevent loss of range of motion (ROM)	20895		

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20895	Continued from page 8 for 8 of 8 residents (R7, R5, R3, R11,R17,R30,R33, R39) reviewed. Findings include: R7's significant change Minimum Data Set dated 6/6/25, identified R7 had moderate cognitive impairment and diagnosis of hypertension (elevated blood pressure), and end stage renal disease (ESRD) and required moderate assist with activities of daily living (ADL's) which include bed mobility toileting and transfers. R7 had impairment on one side of upper extremity. R7's ADL Care Area Assessment (CAA) dated 6/18/25, identified R1 had physical limitations such as, limited range of motion, poor coordination, poor balance, visual impairment, or pain. Identified R7 was at risk for complications of immobility such as contractures. R7's care plan revised 7/18/25, had a self-care deficit related to impaired balance and right (R) sided upper extremity weakness. R7 was independent to walk with a walker. Care plan identified PT/OT (physical/occupational therapies) to treat and evaluate as needed. R7's OT assessment dated 1/7/25, identified R7 had a functional impairment of the left shoulder and forearm and R7 had no functional impairment of the right shoulder and forearm. R7's OT discharge assessment dated 2/4/25, identified discharge recommendations to complete a functional maintenance (FMP) program of right shoulder and elbow 7 times per week. Assessment did not indicate any functional impairment of the right hand. R7's medical record lacked evidence the FMP program had been initiated after the 2/4/25 OT recommendations. R7's PT evaluation dated 3/21/25, identified Current Referral Reason R7 referred to PT due to staff wondering about a platform walker for her due to not using her R arm post CVA hx. R7 tends to rest her R hand on her walker vs holding onto it. Reason for Skilled Services: Skilled therapy necessary to assess need for platform walker and trial; however, she declines adamantly. R7 record lacked any further follow up or additional interventions related to her R hand. During two separate observations one on 7/29/25 at 5:48 p.m. and other on 7/30/25 at 8:42 a.m, R7 was pushing a	20895		

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20895	Continued from page 9 front wheeled walker using her left hand with her right hand down at her side. R7's fingers on her right hand were curled inward. R7 returned to her room and sat down in her recliner using her left hand to touch the recliner as she sat down. During an observation and interview on 7/30/25 at 9:34 a.m., OT opened R7's fingers on the right hand and R7 yelled "ouch that hurts." OT did a full assessment of R7's right hand and stated R7 had significant contractures to the thumb and all four fingers on the right hand. OT stated when R7 was admitted to the facility six months ago R7 had mild tightness to her right hand and no contractures. OT stated R7 has had a significant decline in her ROM in her right hand since admission to the facility six months ago. R7's OT evaluation dated 7/30/25, identified R7 was referred to skilled OT due to decreased ROM of her fingers on the right hand, limiting her ability to participate in ADL's and functional mobility. R7 had redness on the tip of her thumb due to it being in between her 3rd and 4th fingers. Area does blanch when pressure is applied. R7 had pain while attempting to assess right hand and ROM. During an interview on 7/30/25 at 10:02 a.m., activities aide (AA)-A stated she had noticed in the past few months R7 was not able to open her right hand and the fingers on her right hand had curled in wards. AA-A stated she had not told anyone because she assumed the facility was aware of R7's decreased ROM and inability to open her right hand. During an interview on 7/30/25 at 10:10 a.m., nursing assistant (NA)-B stated R7's right hand was a little tight when R7 was admitted to the facility six months ago but in the past two months R7's ROM in her right hand has decreased and R7 no longer was able to open her right hand. NA-B did not think R7 had any functional maintenance programs. NA-B stated she did not tell anyone and stated she should have told the nurses about R7's decreased ROM in her right hand. During an interview on 7/30/25 at 10:13 a.m., NA-A stated R7 had some weakness in her right hand when she was admitted to the facility six months ago. NA-A stated up until two months ago R7 was able to fully open her right hand without pain. NA-A stated R7 has been complaining of pain in her right hand for the past 2 months and was no longer able to open her right hand. NA-A stated she had not told anyone about the decline in R7's ROM or complaints of pain because she assumed the nurses were aware.	20895		

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20895	Continued from page 10 During an interview on 7/30/25 at 10:20 a.m., R7 stated she was having more difficulty walking lately because she was unable to use her right hand to push her walker. During an interview on 7/30/25 at 10:28 a.m., registered nurse (RN)-A stated her expectation was that staff would have let her know when R7's ROM in her right hand began to decrease so she could have let the medical doctor (MD) and therapy know to prevent further decreased ROM and contractures. During an interview on 7/30/25 at 11:05 a.m., family member (FM)-A stated three months ago R7 was able to open her right hand to use the FWW walker. FM-A stated in the past two months R7 had complained of pain in her right hand, was no longer able to open her right hand or able to use her right hand to push her walker. During an interview on 7/31/25 at 12:20 p.m., director of nursing (DON) verified R7 had contractures in her right hand . DON stated she was unaware R7 had decreased ROM or developed the contractures in her right hand in the past few months. DON stated it was her expectation any change in a resident's condition be reported to the nurse and the physician so it could be assessed to prevent a decline in ROM and contractures. During an interview on 7/30/25 at 2:35 p.m., medical doctor (MD) stated he did not recall being notified of R7's decline in ROM or contractures to her right hand. MD stated his expectation was the facility would have let him know about R7's decline in ROM to prevent further decline in ROM and prevent contractures from developing. R3 R3's annual Minimum Data Set (MDS) assessment dated 6/3/25, identified R3 was cognitively intact and was dependent on staff for all activities of daily living (ADLs). R3 had a diagnosis of hypertension (high blood pressure), diabetes, and hemiplegia (one-side weakness). R3's care area assessment (CAA) dated 5/29/25, indicated R3 was at risk for developing contractures and R3 had restricted mobility. R3's physical therapy (PT) orders signed 5/3/24, R3 was set up with a ROM/orthotic program. On 7/24/25, PT placed orders for R3 to stand one time a shift on day and night shift with platform walker, with the assist	20895		

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20895	Continued from page 11 of two at the edge of the bed. PT orders lacked documentation on the length of time R3 was to stand with staff. R3's care plan dated 6/27/25, indicated R3 was to receive gentle range of motion (ROM) as tolerated with daily care. R3's care plan lacked information providing what extremity R3 was to have ROM completed on. R3's electronic treatment administration record (eTAR) dated 7/25, lacked documentation R3 was to receive ROM or stand at the edge of the bed with a platform walker and a assist of two. R3's progress notes dated 5/1/25 to 7/30/25, lacked documentation R3 was to receive gentle ROM as tolerated with daily cares. During an interview on 7/30/25 at 1:31 p.m., PT-A confirmed R3 was on a standing program with staff two to three times a day. PT-A indicated the orders were provided to nursing staff to enter the orders on R3's care plan. During an interview on 7/30/25 at 1:47 p.m., NA-E indicated NA-E was unaware R3 had orders to stand one time a shift on day and night shift with platform walker, with the assist of two at the edge of the bed. NA-E further indicated staff do not have time to complete ROM on residents daily. R5 R5's admission Minimum Data Set (MDS) assessment dated 6/3/25, identified R5 was severely cognitively impaired and needed moderate assistance with all activities of daily living (ADLs). R5 had a diagnosis of dementia, diabetes, and anxiety, R5's care area assessment (CAA) dated 5/26/25, indicated R5 was at risk for developing pressure ulcers. R5's care plan dated 6/14/25, indicated R5 required the assist of one with a walker and gait belt for ambulation. R5's physical therapy (PT) orders signed 5/14/25, R5 was to transfer with the assist of one with walker. R5's eTAR dated 7/25, lacked documentation R5 was being ambulated with the assist of one with walker and gait belt.	20895		

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20895	Continued from page 12 R5's Kardex Report dated 7/30/25, indicated R5 required the assist of one with a walker and gait belt for ambulation. R5's progress notes dated 5/13/25 to 7/30/25, lacked documentation R5 was receiving the assistance of one with walker and gait belt for ambulation. R11 R11's quarterly Minimum Data Set (MDS) dated 4/28/25, identified R11 was severely cognitively impaired and was dependent on staff for all activities of daily living (ADLs). R11 had a diagnosis of dementia, hypertension (high blood pressure), and deep vein thrombosis (DVT) (blood clot). R11's care area assessment (CAA) dated 10/23/24, indicated R11 was at risk for pressure ulcers and pain due to body positioning. R11's care plan dated 3/10/25, indicated R11 was to receive passive range of motion (PROM) to all extremities. R11's care plan lacked information indicating how often staff were to perform PROM for R11. R11's physical therapy (PT) orders signed 9/26/24, identified R11 presented with impaired ROM and position of joints consistent with R11's level of dementia. R11 was a good candidate for set up of ROM program. R11's eTAR dated 7/25, lacked documentation R11 was receiving PROM. R11's Kardex Report dated 7/30/25, lacked documentation R11 was to receive PROM. R11's progress notes dated 5/1/25 to 7/30/25, lacked documentation R11 was receiving PROM. R30 R30's quarterly Minimum Data Set (MDS) assessment dated 4/29/25, identified R30 was cognitively intact and needed minimal assistance with all activities of daily living (ADLs). R30 had a diagnosis of hypertension (high blood pressure), dementia, and a traumatic brain injury (TBI) R30's care area assessment (CAA) dated 1/16/25, indicated R30 was at risk for loss of arm or leg movement and pressure ulcers.	20895		

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20895	Continued from page 13 R30's care plan dated 1/14/25, indicated R30 was to receive PROM with the assist of one staff to the lower extremity. R30's care plan lacked information on what lower extremity was to receive PROM. R30's physical therapy (PT) orders signed 4/15/24, identified education was provided to nursing on completing ROM program. PT orders lacked information identifying what education was provided to nursing and where R30 was to be receiving ROM. R30's electronic treatment record (eTAR) dated 7/25, lacked documentation R30 was receiving ROM on R30's lower extremity. R30's Kardex Report dated 7/30/25, lacked documentation R30 was to receive ROM on R30's lower extremity. R30's progress notes dated 5/1/25 to 7/30/25, lacked documentation R30 was receiving ROM on R30's lower extremity. R33 R33's quarterly Minimum Data Set (MDS) assessment dated 5/20/25, identified R33 was severely cognitively impaired and dependent on staff with all activities of daily living (ADLs). R33 had Alzheimer's disease and depression. R33's care area assessment (CAA) dated 11/12/24, indicated R33 was at risk for pressure ulcers and pain. R33's care plan dated 4/28/25, indicated R33 was to receive lower extremity, upper extremity, and neck PROM exercises. R33's care plan lacked information identifying what lower and upper extremity was to receive PROM. R33's physical therapy (PT) orders signed 4/15/20, nursing staff ROM program has been implemented and staff educated. R33's electronic treatment record (eTAR) dated 7/25, lacked documentation R33 was receiving lower extremity, upper extremity, and neck PROM exercises. R33's progress notes dated 5/1/25 to 7/30/25, lacked documentation R3 was receiving lower extremity, upper extremity, and neck PROM exercises. During an interview on 7/30/25 at 12:46 p.m., NA -A revealed the facility no longer had a restorative aid.	20895		

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20895	Continued from page 14 NA-A indicated there were several residents on a restorative program and staff were required to complete restorative therapy when assisting residents up in the morning. NA-A further indicated staff did not have enough time to complete all the needs of the residents which included restorative therapy. During an interview on 7/30/25 at 12:56 p.m., LPN-A stated NAs were responsible for completing restorative therapy on residents. LPN-A further stated the facility had not had a restorative program for about a year and a half. LPN-A indicated staff had never let her know if residents had refused restorative therapy, but she would expect them to let the nurse know. LPN-A further indicated if a resident refused it should have been documented in the residents' notes. During an interview on 7/30/25 at 1:03 p.m., OT-B stated NAs were trained on how to perform restorative therapy on residents with orders from PT/OT (physical/occupational therapy). OT-B further stated if staff did not know how to perform therapy, they would receive additional training and guidance from PT/OT. OT-B indicated all restorative therapy orders were written in the residents' care plans. During an email interview on 7/30/25 at 2:05 p.m., director of nursing (DON) indicated the ROM restorative therapy information is stored on the Kardex however, staff do not sign off that restorative therapy was completed. During an interview on 7/30/25 at 2:35 p.m., LPN-B stated R3s restorative therapy orders would have shown up on the NAs task list to be completed. LPN-B indicated NAs should have been letting nursing staff know if residents were refusing therapy. LPN-B further indicated LPN-B was unaware of any residents refusing therapy. During an interview on 7/30/2025 at 3:30 p.m., PT-B stated orders were put on a sheet and placed in a binder. PT-B further stated the binder used to be in the activities room, but PT-B did not know where the binder went. PT-B indicated the previous process changed when the new system took place and now the sheets are placed in the unit managers bin to be added to the care plans. During an interview on 7/30/25 at 5:15 p.m., DON confirmed the above findings and stated her expectations was staff were to be following the Kardex and care plan to get exercises completed. DON stated she was unaware why the restorative therapy orders were	20895		

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20895	Continued from page 15 not linking to the tasks so staff could sign them off when they were completed. DON further stated it was important for residents to receive restorative therapy so there is not a decline in the residents or if a decline is noted the resident could be referred to PT/OT. R17 R17's quarterly Minimum Data Set (MDS) assessment dated 6/3/25, identified R17 as having severe impaired cognition. R17 needed extensive assistance for all activities of daily living (ADLs). R17 had a diagnosis of peripheral vascular disease (narrowing of the blood vessels), arthritis, and hypertension (high blood pressure). No restorative nursing programs was indicated on the MDS. R17's Care Area Assessment (CAA) dated 11/8/24, identified R17 had physical impairments such as weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. R17's signed occupational therapy orders dated 12/11/23, revealed occupational therapist (OT) ordered an restorative nursing program to help with carryover and consistency for left upper extremity ROM. Orders included left upper extremity passive range of motion/ active range of motion for elbow flex/extend, shoulder protraction/ retraction/ flex/extension, horizontal abduction/adduction, and wrist flex/extend to help increase flexibility for ADL/s five repetitions with each exercise. R17's care plan dated 10/23/24, indicated R17 was at risk for contractures related to left hemiparesis following a cerebrovascular accident (CVA). The goal was to maintain shoulder range of motion (ROM) by participating in ROM exercises. Nursing was to assist in passive ROM to the left upper extremity shoulder, elbow, and wrist flexion/ extension and abduction/ adduction, all 10 repetitions, two sets. Cue R17 to rest and relax between sets. Three to five times a week, as R17 would allow. R17's medical record under the tasks lacked a restorative program. During an interview on 7/30/25 at 9:13 a.m., licensed practical nurse (LPN)-A indicated that the nursing assistants performed restorative programs, which include ROM. During an observation on 7/30/25 at 9:25 a.m., R17 was	20895		

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20895	Continued from page 16 sitting in the dining room with left elbow and hand on a padded wheelchair armrest. During an interview on 7/30/25 at 10:42 a.m., occupational therapist (OT)-A indicated that on 12/11/23, OT set up a restorative program for R17. During an interview on 7/30/25 at 1:20 p.m., physical therapist (PT)-B indicated that on 12/11/23, OT set up a ROM program for staff to complete and it was not discontinued. R39 R39's quarterly Minimum Data Set (MDS) assessment dated 7/1/25, identified R39 was severely cognitively impaired and needed extensive assistance with all activities of daily living (ADLs). R39 had a diagnosis of Lewy bodies (affects cognitive and motor functions), Parkinson's (movement disorder), and hypertension (high blood pressure). No restorative nursing programs was indicated on the MDS. R39's CAA dated 12/5/24, identified R39 had assistance with eating, needed assistance with toileting. R39 had cognitive impairment, dementia, and neuromuscular functional risk factors. R39's signed occupational therapy orders dated 6/24/24 indicated R39 would continue to need ROM assistance to help improve ROM. R39 was unable to complete ROM on her own; nursing staff were educated on how to provide ROM for R39. On 6/19/24, the staff received an education sheet on how to complete ROM exercises and indicated ROM was to be done once in the morning and once in the evening. The education sheet provides pictures on how to perform elbow, forearm, shoulder, and wrist ROM. R39's care plan dated 10/24/24, indicated R39 had a passive ROM program to the upper and lower extremities, three times a week as able. R39's medical record under the tasks lacked a restorative program. During an interview on 7/30/25 at 10:42 a.m., occupational therapist OT-A indicated that OT would ask nursing staff quarterly if there were any changes with residents. Nursing staff had not discussed any changes to OT regarding R39. OT-A indicated on 6/24/24, R39 was placed on a ROM program for the elbow and hand for the nursing staff to complete.	20895		

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20895	Continued from page 17 During an interview on 7/30/25 at 1:08 p.m., physical therapist (PT)-A indicated that on 6/19/24, R39 received orders to continue the restorative program. PT-A confirmed the ROM was not discontinued and would expect staff to continue as R39 tolerated. During an interview on 7/30/25 at 1:44 p.m., NA-A indicated residents participating in a restorative program had a spot in the tasks section on the computer to alert staff of their participation in the restorative program. NA-A viewed the task section for R17 and R39 and indicated that R17 and R39 lacked documentation of a restorative program needed to be performed. During an interview on 7/30/25 at 1:45 p.m., nursing assistant (NA)-B indicated there was no restorative aid in the facility, and the nursing assistants were responsible for performing ROM on residents who had a restorative program. If a resident had a restorative program, the computer would show this in a task section. NA-B indicated R17 and R39 did not have a restorative program, as there was no information in the task section of the computer's Kardex, which the nursing assistants used to identify who had a restorative program. During an interview on 7/30/25 at 3:30 p.m., registered nurse (RN)-A indicated the process was for OT to place restorative orders in a box by the nurse station. RN-A would take the orders and place them in the care plan, then give a copy of the orders to the staff. The facility received a new computer system this past year, and when the restorative program is placed into the care plan, it would populate on the nursing assistant's Kardex tasks on the computer. RN-A indicated that no issues were reported altering staff the Kardex task did not pull from the care plan. The facility policy titled Restorative Nursing Program, dated 4/6/20, identified the facility will have a restorative nursing program that promotes a resident's ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care. Procedure: Residents will be evaluated on admission, ongoing and at least quarterly to determine the need for restorative nursing services by the Restorative Coordinator or nursing-designed and/or contracted therapy. The Restorative Coordinator or designee will inquire as to the resident’s interest in participating with the recommended restorative nursing services, if applicable. If the resident	20895		

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20895	Continued from page 18 declines/refuses recommended restorative A nursing services, an Informed Choice Consent form will be completed with the resident and/or resident representative regarding the risks and benefits of the services recommended by the Restorative Coordinator or designee and/or Contracted Therapy. The Restorative Nursing Coordinator or nursing designee will develop the program(s), in collaboration with Therapy if the program is recommended by Therapy, for residents who are identified as having the potential to benefit from the program(s). The Restorative Nursing Coordinator or nursing designee will develop the program(s), in collaboration with Therapy if the program is recommended by Therapy, for residents who are identified as having the potential to benefit from the program(s). A Restorative Assessment will be completed by the RN Restorative Coordinator or by nursing staff under the supervision of the RNC. This will include identifying and care planning the residents' need for restorative nursing services, goal(s), and interventions to meet the goal(s). When a resident is started on a RNP or has a change to their current RNP, the Restorative Coordinator or designee will communicate these changes with the resident, the nursing department and any staff who provide restorative nursing services. Restorative Coordinator or designee will keep the nursing leadership team and providers informed of resident's progress in regard to restorative nursing services, as needed. Restorative Coordinator or designee (must be a registered nurse) and/or Contracted Therapy will train the restorative staff on restorative techniques and individual restorative Nursing program(s). Restorative staff will show competency in restorative nursing programs. Training will be completed on an ongoing basis, as needed. Restorative staff will be responsible for providing the residents with restorative nursing services and will document completion. If a resident is refusing restorative nursing services or has had a change in condition/function, the restorative staff will report to the Restorative Coordinator or designee and the Nurse Supervisor in a timely manner. Documentation of non-compliance will include reason for refusal and any intervention(s) to promote compliance. If resident continues refusal of RNP after implementing interventions and education to promote compliance, the Restorative Coordinator or designee may complete an Informed Choice Consent form with the resident and/or resident representative. The Restorative Coordinator or designee will ensure documentation of the restorative program is complete. Restorative Coordinator or designee will meet with staff performing restorative services routinely to review programs, review documentation, and make recommendations in regard to	20895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Wind Village	**1001 SCOTTS AVENUE , MORRIS, Minnesota, 56267**

(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
20895	Continued from page 19 restorative nursing services. Restorative Coordinator or designee (Registered Nurse) will evaluate the resident's restorative nursing program at least quarterly and document the evaluation in the electronic health record. The evaluation will include the resident's progress toward the goal, any barriers that interfere with the resident's progress, interventions attempted to assist the resident to overcome the barriers, an assessment of frequent refusals to participate in the restorative program and the rationale for the decision to revise, continue or discontinue the restorative nursing program. Restorative Coordinator or designee will update the restorative care plan, as needed. Restorative Coordinator or designee will monitor on an ongoing basis all aspects of the individualized restorative programs being offered. Audits will be completed as needed to review and identify any trends with the restorative nursing program. The Restorative Coordinator or designee will participate and develop a report for Quarterly QAPI meetings. These reports will help identify any variations and gaps to refer for review, improvement and increased monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents with limited range of motion and ensure restorative programs are being completed to minimize further decline. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk of complications associated from lack of appropriate restorative care. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator
West Wind
Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

RE: CCN: 245262
Cycle Start Date: July 30, 2025

Dear Administrator:

On July 30, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 30, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 30, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 30, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 30, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, West Wind Village will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 30, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
How the facility will identify other residents having the potential to be affected by the same deficient practice.
What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
The date that each deficiency will be corrected.
An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 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.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

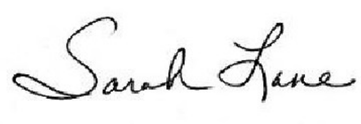
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator
West Wind Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

Re: State Nursing Home Licensing Orders
Event ID: 1OCT11

Dear Administrator:

The above facility was surveyed on July 30, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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:

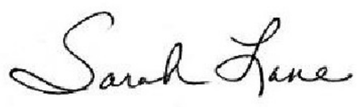
Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 5, 2025

Administrator
West Wind Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

RE: CCN: 245262
Cycle Start Date: July 30, 2025

Dear Administrator:

On August 15, 2025, we notified you a remedy was imposed. On November 4, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 30, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective August 30, 2025, be discontinued as of September 30, 2025. (42 CFR 488.417 (b))

In our letter of August 15, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 30, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 5, 2025

Administrator
West Wind Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

Re: Reinspection Results
Event ID: 1OCT-H2

Dear Administrator:

On August 27, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 07/30/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us