DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2023

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

RE: CCN: 245262
Cycle Start Date: July 12, 2023

Dear Administrator:

On July 12, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, 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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 12, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 12, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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August 14, 2023

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

Re: State Nursing Home Licensing Orders
Event ID: 3JW411

Dear Administrator:

The above facility was surveyed on July 10, 2023, through July 12, 2023, 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245262	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 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
E 000	Initial Comments On 7/10/23 through 7/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		9/11/23

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

Electronically Signed | 08/21/2023

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

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E 037	Continued From page 1 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training	E 037		

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E 037	Continued From page 2 program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the	E 037		

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E 037	Continued From page 3 following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037		

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E 037	Continued From page 4 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 new employees reviewed for emergency preparedness training had received initial training on the emergency preparedness plan. This deficient practice had the potential to affect all 56 residents residing in	E 037	5 of 5 of new employees have completed the Emergency Preparedness training. All new employees were audited and have completed Emergency Preparedness training.	

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E 037	Continued From page 5 the facility. Findings include: Review of nursing assistant (NA) -A New Employee checklist identified NA-A's hire date was 5/2/23. Checklist indicated NA-A had not started Emergency Preparedness training. Review of NA-B's New Employee checklist identified NA-B's hire date was 3/29/23. Checklist indicated NA-B had not started Emergency Preparedness training. Review of NA-C's New Employee checklist identified NA-C's hire date was 5/2/23. Checklist indicated NA-C had not started Emergency Preparedness training. Review of dietary aide (DA)-A New Employee checklist identified DA-A's hire date was 5/16/23. Checklist indicated DA-A had not started Emergency Preparedness training. During an interview on 7/12/23 at 11:05 a.m., a review of the facility's emergency preparedness program review was completed with the administrator. Administrator confirmed NA-A, NA-B, NA-C, and DA-A were all new employees and had not started emergency preparedness training. Administrator stated her expectation was all new employees would have had initial emergency preparedness training upon hire as stated in the emergency preparedness policy. The facility policy titled Emergency Preparedness - Training, Exercise, and Evaluation reviewed 4/1/19 , identified the facility would exercise, evaluate and train staff on the Emergency	E 037	Education policy was reviwed and updated for new hires. Human Resource Director and hiring managers were educated on the new policy. All new employees will complete Emergency Preparedness training upon hire and monitored by their supervisor for completion. Audits to ensure compliance will be conducted by Human Resources at 30 days after a new employee is hired. Audits will be brought to QAPI committee for further recommendations. The department supervisor and human resource director are resonsible for compliance.	

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E 037	Continued From page 6 Preparedness - Disaster Plan to provide direction for staff on exercising and evaluating emergency preparedness. The policy indicated the facility would have provided initial training in the emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. The policy identified after initial training, the facility would provide emergency preparedness training at least annually	E 037		
F 000	INITIAL COMMENTS On 7/10/23 through 7/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H52623335C (MN00094550). H52623336C (MN00093995). H52623336C (MN00093971). H52623338C (MN00088293). H52623337C (MN00087712). H52623339C (MN00083611) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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F 000	Continued From page 7 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on pharmacy recommendations for a dose reduction related to an acid reduction medication for 1 of 5 residents (R12) reviewed for unnecessary medications.	F 757	Resident 12's provider was updated and the acid reduction medication dose was reduced per pharmacy recommendation. All pharmacy recommendations for each	8/25/23

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F 757	Continued From page 8 Findings include: R12's Resident Face Sheet dated 7/12/23, indicated R12 had diagnosis which included gastro-esophageal reflux disease, anxiety, and depression. R12's Physician Order Review signed and dated 6/23/23, indicated R12 currently had an order for Famotidine (acid reducing medication) 40 milligram (mg) daily at breakfast. Review of R12's progress notes from 5/1/23 to 7/12/23, revealed the following: - On 5/19/23 at 11:21 a.m., the pharmacist recommended to decrease R12's Famotidine from 40 mg to 20 mg daily based on her current renal function and an accumulation of Famotidine in the body could cause an increase in anticholinergic effects in the central nervous system (CNS) placing R12 at an increased risk of confusion. Review of R12's Consultant Pharmacist Drug Regimen Review Summary dated 5/19/23, a recommendation had been made to decrease R12's Famotidine due to her creatinine level. R12's medical record lacked documentation R12's primary physician had reviewed, made recommendations or provided rationale for continued use of R12's current order of Famotidine 40 mg daily. During an interview on 7/12/23 at 1:07 p.m., registered nurse (RN)-A confirmed the above findings and indicated she could not recall if she had communicated the recommendations to	F 757	resident were reviewed and addressed with each provider. The "Drug Regimen Review" policy was reviewed and updated. Each recommendation receieved from the pharmacy consultant will be reviewed and printed for the provider to review on their next scheduled rounds. If the recommendation needs immediate attention, the RN Unit Manager/Charge Nurse will notify the provider immediately. All recommendations will be audited to ensure they have been addressed. Unit Manager/Charge Nurse will be educated on the revised policy and procedure to ensure compliance. Audits will occur after each pharmacy consultant visit and continue three times per week until all recommendations have been addressed. Audits will be brought to the QAPI committee for further recommendations. Director of Nursing or Designee is responsible for compliance.	

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	245262	A. BUILDING _____ B. WING _____	C 07/12/2023

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F 757	Continued From page 9 R12's primary physician. RN-A stated the facility's usual practice was to print out the pharmacy drug recommendations, communicate the results to the primary physician during rounds and to ask the primary physician to address the recommendations in a timely fashion. During an interview on 7/12/23 at 1:22 p.m., the director of nursing (DON) confirmed the above findings and indicated she would expect nursing staff to follow pharmacy recommendations and the facility policy. The DON indicated the facility's usual practice for pharmacy recommendations included the nursing staff would print the recommendations out, communicate the recommendations to the primary physician and to document the results of the physician's review. Review of facility policy titled, Drug Regimen Review dated 10/8/18, indicated the pharmacy consultant would conduct a drug regimen review (DDR) at least once a month to help manage drug regimens and identify and address suspected or confirmed medication issues. The DDR would include review of each resident's drug regimen to identify and discontinue potentially unnecessary drugs. After the DDR was complete any irregularities noted by the pharmacist would be documented on a separate written report and sent to the DON .	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		9/1/23

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F 758	Continued From page 10 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 11 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident was reassessed for continued use of an as needed (PRN) psychotropic medication, Xanax (anti-anxiety), beyond the 14 days for 1 of 5 residents (R202) who was reviewed for unnecessary medications. Findings include: R202's admission Minimum Data Set (MDS) dated 6/16/23, identified R202 was cognitively intact and had diagnoses which included: cancer, diabetes mellitus and depression. Identified R202 required extensive assistance of one staff with bed mobility, transfers, dressing, personal hygiene and toileting. Indicated R202 had no behaviors and received anti-depressant and anti-anxiety medication. R202's service plan dated 6/11/23, identified R202 had a potential problem related to use of Xanax for anxiety related to her current health condition. R202's service plan identified R202 was very anxious and had interventions which included the following: - Observe for side effects of medications, - Observe for changes in behaviors, make referrals, and update primary provider, - Observe for changes in behavior, - Explain all cares being provided, and - Utilize current support system. Review of R202's progress notes from 6/9/23 to 7/12/23, revealed the following:	F 758	Resident 202's psychotropic medication order was clarified with the provider and PRN dose was discontinued. All resident charts were reviewed for PRN psychotropic use and reassessed for continued use. Facility's Psychotropic Medication policy was reviewed and updated. A Psychoactive Medication Duration and Rational form for providers was implemented. Unit managers were educated on the revised policy and procedure to maintain compliance. Pharmacy will complete a medication safety inservice for Unit Managers. PRN Psychotropic Drug Use and Reassessments will be audited weekly for 4 weeks then bi-monthly for 4 weeks, then monthly. Results will be brought back to QAPI for further recommendations. DON or designee is responsible for compliance.	

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F 758	Continued From page 12 - On 6/12/23, at 12:04 p.m., the pharmacist recommended a review of R202's Xanax per long term care (LTC) regulations. Review of R202's Consultant Pharmacist Drug Regimen Review Summary (DRR) dated 6/16/23, identified the facility needed to address R202's Xanax as previously noted on 6/12/23, initial pharmacy review. R202 had PRN Xanax 0.25mg to be reviewed by the provider per long term care (LTC) regulations for continued use past 14 days. Review of R202's Physician Progress notes from 6/9/23 to 7/12/23, revealed the following: - On 6/16/23, R202 was seen by her primary provider, and he indicated R202 had squamous cell carcinoma of the right lung with brain metastases and identified R202 had anxiety about her health. R202's daughter had concerns regarding R202's panic attacks and anxiety. R202 previously had an order for Xanax PRN, order changed to scheduled Xanax 0.25 mg twice daily. The plan was to follow-up and adjust dose as needed. -On 6/29/23, R202 was seen by her primary provider and the provider indicated R202's scheduled dose of Xanax twice daily had been helpful for managing her anxiety. Review of R202's Physicians Orders signed and dated on 6/16/23, indicated R202 had received an order from her primary physician for Xanax 0.25 milligrams (mg) two times daily. Review of R202's medication administration record (MAR) summary from 6/1/23 to 7/12/23, identified the following:	F 758		

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F 758	Continued From page 13 - on 6/22/23, R202 had received a PRN dose of Xanax 0.25 mg at 8:08 p.m. - on 6/30/23, R202 had received a PRN dose of Xanax 0.25 mg at 4:15 p.m. - on 7/3/23, R202 had received a PRN dose of Xanax 0.25 mg at 11:58 a.m. Review of R202's medical record indicated R202 continued to receive PRN Xanax 0.25 mg along with Xanax 0.25 mg scheduled two times daily following her primary physician discontinued the PRN dose on 6/16/23. During a telephone interview on 7/12/23 at 12:09 p.m., the consulting pharmacist (CP) confirmed he had reviewed R202's admission orders and had made recommendations for the provider to address continued use of PRN Xanax after 14 days. The CP indicated a medication error had occurred when staff continued to administer the PRN Xanax in addition to the regular scheduled doses. The CP indicated he reviewed the residents' medications upon admission and monthly thereafter. He stated he needed to complete a medication safety in-service to ensure errors like this did not re-occur. During a telephone interview on 7/12/23 at 8:50 a.m., the primary physician's nurse (PPN) indicated after confirming with R202's primary physician, R202's primary physician wanted R202's PRN Xanax 0.25 mg discontinued on 6/16/23, and had ordered it to be scheduled two times daily instead. During an interview on 7/11/23 at 3:00 p.m., registered nurse (RN)-A confirmed the above findings and indicated she had not discontinued R202's PRN Xanax 0.25 mg on 6/16/23 as	F 758		

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F 758	Continued From page 14 ordered, due to the order being unclear to her. RN-A verified she had not reached out to R202's primary physician for clarification regarding R202's PRN Xanax 0.25 mg. RN-A confirmed R202 continued to receive her PRN Xanax on 6/22/23, 6/30/23, and 7/3/23. In a follow-up interview on 7/12/23 at 12:21 p.m., RN-A indicated she had clarified with R202's PPN R202's PRN Xanax had been ordered to be discontinued back on 6/16/23. During an interview on 7/12/23 at 12:27 p.m., the director of nursing (DON) confirmed the above findings and indicated she would expect nursing staff to call the primary physician for clarification if an order was unclear to them. The DON stated the facility's process was for nursing staff to do rounds with the primary physician and to address any pharmacy recommendations during that time. The DON indicated she would expect nursing staff to process orders as they received them, update the MAR to reflect the updated orders, and to follow the facility policy. Review of the facility policy titled, Physician's Orders undated, indicated nursing staff were expected to obtain an order from the physician, transcribe the order, complete a progress note describing the reason the order was made and notify family. If a medication was discontinued, staff were to remove the medication cassette from the medication cart and the MAR should reflect the changes. Review of the facility policy titled, Psychotropic Medications dated 10/1/15, indicated: -The primary physician would document a rationale and diagnosis for the use of the psychotropic medication. The primary physician	F 758		

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F 758	Continued From page 15 would evaluate the effects of the psychotropic within one month and during routine visits thereafter. -Nursing staff would monitor the resident for side effects of the psychotropic medication and review continued use with the primary physician. -The Pharmacist would monitor the resident on psychotropic medications to ensure they were not being used excessively and notify the primary physician or nursing staff if the psychotropic medication was due for review.	F 758		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		9/1/23

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F 883	Continued From page 16 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R46, and R47) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC recommendations	F 883	Resident R47 and R46 or representative were offered the PCV-20 and provided education on the benefits and potential side effects. All residents MIIC/immunization record were reviewed. All residents, or their resident representative, eligible to receive the PCV-20 were offered the vaccine and	

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F 883	Continued From page 17 3/15/2023, revealed The Center for Disease Control and Prevention (CDC) identified Adults 65 years of age or older who had not previously received Pneumococcal 13-valent Conjugate Vaccine (PCV13) and who had previously received one or more doses of Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should receive a dose of Pneumococcal 15-valent Conjugate Vaccine (PCV15) or one dose of Pneumococcal 20-valent Conjugate Vaccine (PVC20). The dose of PCV15 or PCV20 should be administered at least one year after the most recent PPSV23 dose. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 was received at age 65 and older, based on shared clinical decision-making, one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R47's facesheet, R47, age 87, was admitted to the facility on 11/22/22. Review of R47's Minnesota Immunization Information Connection (MIIC) undated, identified R47 had received the Pneumo-PPSV23 on 11/04/2009, and the Pneumo-PPSV23 on 10/01/2018. R47's medical record lacked documentation R47 had received or been offered the PCV15 or PCV20 vaccines. Review of R46's facesheet, R46, age 80, was admitted to the facility on 3/24/23. Review of R46's Minnesota Immunization Information Connection (MIIC) undated, identified R46 had received the Pneumo-PCV13 on 11/04/2015, and received Pneumo-PPSV23 on 1/20/2017. R46's medication record lacked documentation R46 had received or been offered the PVC20 vaccine. During an interview on 7/12/23 at 9:30 a.m.,	F 883	provided education regarding the benefits and potential side effects of the pneumococcal vaccine. All residents accepting the offered vaccine will be immunized. The "Resident Immunizations Policy" was reviewed and updated with the most current CDC recommendations. Nurse Managers and IPCO nurses were educated on the updated policy. The IPCO nurse will review each new admit's vaccination record and offer the PCV 20 to all eligible residents at the time of admission. If resident is not eligible a the time of admission, the PCV 20 will be offered when they become eligible. Current residents who are not eligible at this time, will be offered the PCV 20 when they become eligible. Current residents and new admissions vaccination records will be audited monthly to ensure the PCV 20 was offered by the IPCO nurse or designee. Results will be brought to QAPI committee for further recommendations. IPCO Nurse and Director of Nursing are responsible for compliance.	

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F 883	Continued From page 18 registered nurse (RN)-A stated the facility's usual process was to review the resident's MIIC report upon admission to determine if there was a need for a pneumococcal vaccine. RN-A verified the facility referred to the CDC Pneumococcal Vaccine Timing for Adults dated 4/01/2022, to assist in determining if more vaccines should be offered and was not aware the guidelines had recently been updated. RN-A confirmed R47 and R46 had not been offered or received the pneumococcal vaccinations as recommended by the CDC. During an interview on 7/12/23 at 9:25 a.m., infection preventionist (IP)-A stated the facility's policy was to offer and administer the pneumococcal vaccine according to the CDC recommendations. IP-A indicated her usual practice was to review the resident's MIIC report upon admission and provide the MIIC report information along with the CDC recommendations to the RN unit manager. IP-A indicated she was not aware the CDC recommendations had recently been updated. IP-A confirmed R47 and R46 had not been offered or received the pneumococcal vaccinations as recommended by the CDC. During an interview on 7/12/23 at 1:13 p.m., with director of nursing (DON) confirmed the facility process was for staff to review the MIIC report and to administer pneumococcal vaccinations according to the CDC recommendations. DON stated she was not aware the CDC recommendations had recently been updated. DON confirmed R47 and R46 had not been offered or received the pneumococcal vaccinations as recommended by the CDC.	F 883		

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F 883	Continued From page 19 The facility policy titled Resident Immunization dated 12/2/22, identified pneumococcal vaccines would be offered to each resident according to the current recommendations from the CDC on admission to the facility.	F 883		

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	245262	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, West Wind Village was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

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

Electronically Signed | 08/21/2023

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

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	245262	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	**1001 SCOTTS AVENUE** **MORRIS, MN 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
K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The West Wind Village was constructed at four different times. The original building was built in 1962, is 1-story, with a basement, and was determined to be of a Type V (111) construction because of wood found in parts of the roof system and an outside storage room that was added to the southeast of the East Wing. In 1972 additions were constructed to the west and east	K 000		

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K 000	Continued From page 2 of the original building. They are 1-story, without a basement, and were determined to be Type II (000) construction. In 1976 an addition was built to the northwest of the original building; it is 1 story without a basement and was determined to be Type II (000) construction. In 1999 a secured unit was added to the northwest addition and is 1-story without a basement and was determined to be Type II(000). The building is divided into 6 smoke zones on the main floor. West Wing Pod addition 02 of West Wind Village Care Center consists of a 2015 building addition and is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (000) construction. The facility is fully fire sprinkler protected and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 72 beds and the census was 56 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 293		9/13/23

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K 293	Continued From page 3 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/11/2023 between 10:00 AM and 02:00 PM, it was revealed by observation there was no exit sign above the door or in the vicinity of the employee break room exit. An interview with the Director of Maintenance and the Administrator verified this deficient finding at the time of discovery.	K 293	Exit sign was added to exit door near the employee break room. All exit doors have been reviewed and have exit sign above them or will have an exit sign added. Environmental Services Director will evaluate new doors for the need for an exit sign. Results will be brought to QAPI committee for further recommendations. Administrator and Environmental Services Director are responsible for compliance.	

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	00654	A. BUILDING: _____ B. WING _____	C 07/12/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/10/23, through 7/12//23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction order is issued. Please indicate in your electronic plan of correction you have reviewed the order and	2 000		

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2 000	Continued From page 1 identify the date when it will be completed. In addition to the licensing survey, the following complaints were reviewed during the survey. H52623335C (MN00094550). H52623336C (MN00093995). H52623336C (MN00093971). H52623338C (MN00088293). H52623337C (MN00087712). H52623339C (MN00083611). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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	2 000		

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2 000	Continued From page 2 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not	21535		8/25/23

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21535	Continued From page 3 subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up on pharmacy recommendations for a dose reduction related to an acid reduction medication for 1 of 5 residents (R12) reviewed for unnecessary medications. Findings include: R12's Resident Face Sheet dated 7/12/23, indicated R12 had diagnosis which included gastro-esophageal reflux disease, anxiety, and depression. R12's Physician Order Review signed and dated 6/23/23, indicated R12 currently had an order for Famotidine (acid reducing medication) 40 milligram (mg) daily at breakfast. Review of R12's progress notes from 5/1/23 to 7/12/23, revealed the following: - On 5/19/23 at 11:21 a.m., the pharmacist recommended to decrease R12's Famotidine from 40 mg to 20 mg daily based on her current renal function and an accumulation of Famotidine in the body could cause an increase in anticholinergic effects in the central nervous system (CNS) placing R12 at an increased risk of confusion. Review of R12's Consultant Pharmacist Drug Regimen Review Summary dated 5/19/23, a recommendation had been made to decrease R12's Famotidine due to her creatinine level. R12's medical record lacked documentation	21535	Corrected	

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21535	Continued From page 4 R12's primary physician had reviewed, made recommendations or provided rationale for continued use of R12's current order of Famotidine 40 mg daily. During an interview on 7/12/23 at 1:07 p.m., registered nurse (RN)-A confirmed the above findings and indicated she could not recall if she had communicated the recommendations to R12's primary physician. RN-A stated the facility's usual practice was to print out the pharmacy drug recommendations, communicate the results to the primary physician during rounds and to ask the primary physician to address the recommendations in a timely fashion. During an interview on 7/12/23 at 1:22 p.m., the director of nursing (DON) confirmed the above findings and indicated she would expect nursing staff to follow pharmacy recommendations and the facility policy. The DON indicated the facility's usual practice for pharmacy recommendations included the nursing staff would print the recommendations out, communicate the recommendations to the primary physician and to document the results of the physician's review. Review of facility policy titled, Drug Regimen Review dated 10/8/18, indicated the pharmacy consultant would conduct a drug regimen review (DDR) at least once a month to help manage drug regimens and identify and address suspected or confirmed medication issues. The DDR would include review of each resident's drug regimen to identify and discontinue potentially unnecessary drugs. After the DDR was complete any irregularities noted by the pharmacist would be documented on a separate written report and sent to the DON .	21535		

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21535	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures for proper monitoring of pharmacy consultant recommendations. Nursing staff could be educated as necessary to the importance of the pharmacist's review and follow up. The DON or designee could audit medication reviews on a regular basis to ensure compliance. TIME FRAME FOR CORRECTION: twenty-one (21) days.	21535		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 18, 2023

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

RE: CCN: 245262
Cycle Start Date: July 12, 2023

Dear Administrator:

On September 14, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 18, 2023

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

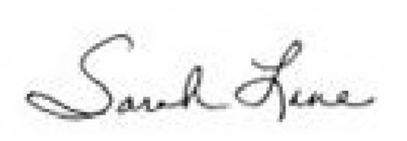
Re: Reinspection Results
Event ID: 3JW412

Dear Administrator:

On September 14, 2023 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 July 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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