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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7XMX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00654

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245262**
2.STATE VENDOR OR MEDICAID NO.
(L2) **482343500**

3. NAME AND ADDRESS OF FACILITY
(L3) **WEST WIND VILLAGE**
(L4) **1001 SCOTTS AVENUE**
(L5) **MORRIS, MN** (L6) **56267**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/02/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **80** (L18)
13.Total Certified Beds **80** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 05/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/09/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245262

June 5, 2016

Ms. Paula Viker, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

Dear Ms. Viker:

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

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

Effective April 26, 2016 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 16, 2016

Ms. Paula Viker, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

RE: Project Number S5262028

Dear Ms. Viker:

On March 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 17, 2016, effective April 26, 2016 and therefore remedies outlined in our letter to you dated March 30, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245262		5/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 56267

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 04/11/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 04/26/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) GA/mm	DATE 05/16/2016	SIGNATURE OF SURVEYOR 28034	DATE 05/02/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/17/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245262	A. Building 01 - MAIN BUILDING 01 B. Wing	4/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 56267

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/26/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 05/16/2016	**SIGNATURE OF SURVEYOR** 34764	**DATE** 04/29/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/14/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
245262	A. Building 02 - POD B. Wing	4/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 56267

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/26/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 05/16/2016	SIGNATURE OF SURVEYOR 34764	DATE 04/29/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7XMX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00654

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245262**

2.STATE VENDOR OR MEDICAID NO.
(L2) **482343500**

3. NAME AND ADDRESS OF FACILITY
(L3) **WEST WIND VILLAGE**
(L4) **1001 SCOTTS AVENUE**
(L5) **MORRIS, MN** (L6) **56267**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/17/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
'Tammy Williams, HFE NEII
Date : 04/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 05/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2016

Ms. Paula Viker, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

RE: Project Number S5262028

Dear Ms. Viker:

On March 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a 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:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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 _____	03/17/2016

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a restraint was identified and assessed for use for 1 of 1 residents (R32) with locked brakes on the wheelchair. Findings Include: R32's annual Minimum Data Set (MDS) dated 2/24/16, indicated R32 was severely impaired, required extensive assistance of 2 to transfer and had utilized a wheel chair (w/c). R32 had diagnoses which included Alzheimer's disease	F 221	Wheelchair brakes were unlocked and will be kept unlocked for resident 32, so R 32 can propel own wheelchair. With the exception of transferring residents, staff will keep all resident wheelchair brakes unlocked. The Resident Physical Restraint Policy was reviewed and updated as necessary to include locking resident wheelchair brakes as an example of a restraint. All staff will be educated on the resident	4/11/16

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

Electronically Signed | 04/05/2016

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F 221	Continued From page 1 and unspecified hearing loss. R32's Care Assessment Area (CAA) dated 2/24/16, indicated R32 was able to transfer and ambulate independently when the resident wished to. In addition, R32 was generally transferred manually or mechanically (mechanical lift) due to the resident's cognition and behaviors. R32 continued to be an assist of 2 to 3 staff with a gait belt and had used a walker for ambulation depending on the resident's behaviors. R 32 was mobile in his w/c and the staff would assist the resident with pathfinding. R32 had behaviors which included being physically and verbally aggressive, agitation, yelling and spitting. R32's care plan with a print date of 3/17/16, revealed R32 required 1 to 2 to transfer and 2 when using Pal lift (mechanical device used for transfers). The care plan identified R32 was at risk for falls related to cognitive deficits, required assist as needed with mobility and transfers, and required assistance with mobility in the w/c. R32's care plan did not address the use of the w/c brakes for R32. On 3/17/16, R32's medical record was reviewed and lacked evidence of a restraint assessment in the medical record or the MDS. During continuous observation on 3/14/16, at 4:54 p.m., R32 was seated at the counter area in front of the kitchenette waiting for supper. R32 was seated in his w/c, both w/c breaks were observed locked and R32 was unable to move the w/c. R32 was observed to be rocking himself back and forth in his w/c seat. At 5:56 p.m. NA-B reached down and unlocked R32's brakes on the w/c, wheeled R32 into the living area and reached	F 221	Physical Restraint Policy. Random audits of w/c brakes are conducted to assess if resident w/c brakes are being locked and hindering them from propelling own w/c by the DON/designee 3 times a week for 4 weeks, 2 times a week for 4 weeks and then weekly. Audit results will be brought to the QAPI committee for further recommendations. Date of completion: 4/15/16	

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F 221	Continued From page 2	F 221		

down and locked both brakes on the w/c. R32 was trying to scoot forward in his w/c but was unable to move the w/c. At 6:01 p.m., R32 remained seated in the w/c with both brakes locked, a staff member walked up to R32 and handed the resident a music book and walked away. At 6:28 p.m. R32 remained seated in the w/c with both brakes locked on his w/c.

During observation on 3/15/16, at 8:52 a.m., R32 was observed seated at the counter near the kitchenette and both w/c brakes were observed locked on the w/c. At 8:55 a.m. NA-C unlocked both brakes and brought R32 in the living room area, NA-C had wiped R32's face with a kleenex and covered the resident with a blanket, locked both brakes on the w/c and walked away.

At 12:07 p.m. R32 was seated in his w/c at the counter in the kitchenette area, with both w/c braked observed locked. At 12:19 p.m. LPN-A sat down next to R32 and assisted him to eat his pears for dessert. Both w/c brakes remained in the locked position. At 12:13 p.m. R32 remained seated in a w/c with both brakes in the locked position at the counter in the kitchenette area.

During observation on 3/16/16, at 7:45 a.m., R32 was seated at the counter by the kitchenette and the both w/c brakes were observed locked on the resident's w/c. R32 remained seated in the w/c with both brakes locked until 8:43 a.m., when staff assisted R32 into the tub room for cares.

During observation on 3/17/16, at 7:58 a.m. R32 was seated in his w/c at the counter by the kitchenette and both brakes were observed to be locked on his w/c.

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F 221	Continued From page 3	F 221		

During an interview on 3/16/17, at 9:07 a.m. nursing assistant (NA-A) stated R32 required extensive assistance with his care and indicated R32 would propel occasionally himself around the unit a little bit in his w/c. NA-A stated R32 would roll himself around in his w/c with his feet and stated she had not ever seen R32 apply the w/c brakes independently.

During interview on 3/17/16, at 1:31 p.m. registered nurse (RN-A) confirmed R32's current care plan and stated R32 required one assist for all of his cares unless there were behavior issues then the resident required 2 staff assist. RN-A stated R32 would walk from his bed to the bathroom with a walker, gait belt and sometimes would do a pivot transfer by his bed with staff assist. NA- A stated R32 used a w/c and staff would bring R32 from his room to his table for meals and the commons area .NA-A stated R32 can move his w/c around a little with his feet but needed help with pathfinding. NA-A stated R32 would not move himself in his w/c by himself from room to room but would move himself in his w/c a few feet in any direction. RN-A stated if R32 was seated at the counter, he may move his w/c back and forth from the counter during meal times. RN-A stated she thought the w/c brakes were used on R32's w/c only when he was transferred and couldn't think of any other time the brakes would be used. RN-A stated she was unsure if R32 could apply the w/c brakes independently. RN-A stated if a resident was unable to unlock the w/c brakes themselves then the brakes would be considered a restraint.

During interview on 3/17/16, at 2:09 p.m., the director of nursing (DON) stated R32 had severe cognitive impairment, utilized a w/c, but thought

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F 221	Continued From page 4 he was unable to propel himself in the w/c. The DON stated R32 probably would not use the brakes on his w/c independently. The DON stated if a resident was placed in the middle of a room and the w/c brakes were locked, this would be considered a restraint for the resident. Review of the policy titled Resident Physical Restraint with a review date of 10/5/15, indicated the facilities goal was to maximize the residents independence, functional capacity and their quality of life. Each resident had the right to be free of physical restraints imposed for discipline,convenience and not required to treat the residents medical symptoms. The policy further stated that the least restrictive measures are used and physical restraint usage be kept at a minimum.	F 221		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents rooms were kept in good repair for 9 out of 75 residents rooms (rm 166, rm 118, rm 164, rm 119, rm 159, rm 104, rm 163, rm 172, rm 161) which had damaged doors, door frames, furniture and discolored rings around the base of toilets reviewed during the environmental tour.	F 465	Environmental Services' Preventive Maintenance Policy for the general facility and resident rooms was evaluated and updated. West Wind Village added a "Daily Checklist" for the general facility and a "Quarterly Checklist" for resident rooms, as well as, quarterly audits of resident	4/26/16

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F 465	Continued From page 5 Findings Include: A environmental tour was conducted with the maintenance director (MD) on 3/17/16 at 9:35 a.m. and the MD verified the following findings: -Room 166's bathroom at the base of the toilet there was a brown colored substance around the ensure base of the toilet. - Room 118's bedroom there was a scrape on the lower right side of the room door. In addition, there was an area where paint was scraped off of the wall at the front of the residents bed. -Room 164's inside and the outside of the resident's bathroom door frame had multiple paint chips on it. -Room 119's lower portion of the resident's bathroom door had multiple scrapes on it. -Room 159's dresser and the closet had several chips in the wood work. -Room 104's lower portion of the inside of the resident's bathroom door and on the inside of the connecting rooms bathroom door had scrapes on them. -Room 163's bathroom at the base of the toilet there was a brown colored substance around it and the heater in the bathroom had areas were the register was rusty in color. -Room 172's bathroom at the base of the toilet there was a brown colored substance around it. - Room 161's closet door had a large chip of	F 465	rooms. Maintenance staff will be educated on these new policies and how to use the daily and quarterly checklists. All staff will be educated, at an all staff inservice, on how to report maintenance concerns or problems by either contacting maintenance directly (if it is urgent) or recording it on the maintenance repair log. The resident bathrooms in rooms 161, 163, 166 and 172 will have the brown substance around the base of the toilet removed by maintenance staff. The scrapes, scratches and chipped wood will be repaired on closet doors, bathroom doors, resident room doors and furniture in resident rooms 104, 118, 119, 159, 161, and 164. These rooms will also have all paint scrapes and chips on walls and door frames repaired and touched up. The concerns with the heater in the bathroom in room 163 will be corrected. Resident room audits will be conducted in all resident rooms starting with the oldest part of the building and repairs will be made as identified on the audits by maintenance personnel. Going forward, all resident rooms will be audited quarterly (27 rooms per month) and the results will be reviewed at West Wind Village's quarterly QAPI meetings to monitor and identify trends. Daniel Kittleson, Environmental Services	

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F 465	Continued From page 6 wood missing from it, the second closet in the room had scratches in it. The inside of the resident's bathroom door was scraped and the base of the toilet had a brown colored substance around it During the environmental tour the MD stated he was not aware of the all of the above room issues. The MD stated he was unable to identify what brownish colored substance was present around all of the bases of the toilets, confirmed the rusty room heater and indicated the chips, scrapes and missing woodwork could of been caused from frequent rubbing of the wheelchairs, resident lifts utilized in the facility. The MD indicated when a resident room was empty and not filled right away, they would check the room. In addition, the MD stated the facility had no system in place to check for chipping paint, wood scratches, scratch paint on the doors or call lights and lights working in the facility. On 3/17/16, at 11:10 a.m. the maintenance man (M-A) verified he didn't go into rooms to spot check unless he was checking a water temperature in the room. The M-A stated there was a sign by the break room and staff would write down repairs that were needed. The M-A stated he felt the nurses and housekeeping would tell him if something would need repair. Review of the Maintenance Repair Log and Check list from 1/28/16 to 3/11/16 didn't identify any of the above resident's room issues. Review of the policy titled Physical Environment Safe and Clean Environment with no date on it indicated the facility was to provide a safe,clean comfortable and homelike environment. The	F 465	Director will monitor for compliance.	

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F 465	Continued From page 7 policy identified different items to be checked such as checking door frames, check window sills for worn varnish,splinters and cracks but lack the frequency the items were to be checked.	F 465		

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	245262	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, West Wind Village was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The West Wind Village was constructed at four different times. The original building was built in the 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 of 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, 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. An automatic fire sprinkler system is installed	K 000		

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K 000	Continued From page 2 throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces and in all the sleeping rooms of the 1999 additions. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code. The fire alarm is monitored for automatic fire department notification. Because the original building and the additions meet the construction types required and the entire facility is protected by an automatic fire sprinkler system the facility was surveyed as one building. The facility has a capacity of 80 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: During documentation review on 03/14/2016 between 1330 and 1700, revealed that: 1) Internal piping and gauges have not been	K 062	West Wind Village has scheduled an area sprinkler company to perform the five year maintenance check of the facility[ ]'s sprinkler system in order to maintain the internal piping and gauges. This inspection is scheduled for April 20, 2016. Daniel Kittelson, Environmental Services Director, will record the date of the inspection and keep track of it in the Life	4/26/16

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K 062	Continued From page 3 maintained. Last check that could be found was on 06/11/2008. This deficiency was verified by Environmental Services Director.	K 062	Safety Code book to ensure that the sprinkler system is properly serviced to prevent a reoccurrence.	

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	245262	A. BUILDING **02 - POD** B. WING _____	**03/14/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 14, 2016. At the time of this survey, the wing that was added called "The Pod" of the West Wind Village Care Center was found to be NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245262	A. BUILDING **02 - POD** B. WING _____	**03/14/2016**

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 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency West Wing Pod addition 02 of West Wind Village Care Carenter 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 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 80 beds and the census was 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are	K 062		4/26/16

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K 062	Continued From page 2 inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: During documentation review on 03/14/2016 between 1330 and 1700, revealed that: 1) Internal piping and gauges have not been maintained. Last check that could be found was on 06/11/2008. This deficiency was verified by Environmental Services Director.	K 062	Corrected	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2016

Ms. Paula Viker, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5262028

Dear Ms. Viker:

The above facility was surveyed on March 14, 2016 through March 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00654	A. BUILDING: _____ B. WING _____	03/17/2016

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the Minnesota Department of	2 000		

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2 000	Continued From page 1 Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a restraint was identified and assessed for use for 1 of 1 residents (R32) with locked brakes on the wheelchair. Findings Include: R32's annual Minimum Data Set (MDS) dated 2/24/16, indicated R32 was severely impaired, required extensive assistance of 2 to transfer and had utilized a wheel chair (w/c). R32 had diagnoses which included Alzheimer's disease and unspecified hearing loss. R32's Care Assessment Area (CAA) dated 2/24/16, indicated R32 was able to transfer and ambulate independently when the resident	2 510	Corrected	4/15/16

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2 510	Continued From page 2	2 510		

wished to. In addition, R32 was generally transferred manually or mechanically (mechanical lift) due to the resident's cognition and behaviors. R32 continued to be an assist of 2 to 3 staff with a gait belt and had used a walker for ambulation depending on the resident's behaviors. R 32 was mobile in his w/c and the staff would assist the resident with pathfinding. R32 had behaviors which included being physically and verbally aggressive, agitation, yelling and spitting.

R32's care plan with a print date of 3/17/16, revealed R32 required 1 to 2 to transfer and 2 when using Pal lift (mechanical device used for transfers). The care plan identified R32 was at risk for falls related to cognitive deficits, required assist as needed with mobility and transfers, and required assistance with mobility in the w/c. R32's care plan did not address the use of the w/c brakes for R32.

On 3/17/16, R32's medical record was reviewed and lacked evidence of a restraint assessment in the medical record or the MDS.

During continuous observation on 3/14/16, at 4:54 p.m., R32 was seated at the counter area in front of the kitchenette waiting for supper. R32 was seated in his w/c, both w/c breaks were observed locked and R32 was unable to move the w/c. R32 was observed to be rocking himself back and forth in his w/c seat. At 5:56 p.m. NA-B reached down and unlocked R32's brakes on the w/c, wheeled R32 into the living area and reached down and locked both brakes on the w/c. R32 was trying to scoot forward in his w/c but was unable to move the w/c. At 6:01 p.m., R32 remained seated in the w/c with both brakes locked, a staff member walked up to R32 and handed the resident a music book and walked

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2 510	Continued From page 3 away. At 6:28 p.m. R32 remained seated in the w/c with both brakes locked on his w/c. During observation on 3/15/16, at 8:52 a.m., R32 was observed seated at the counter near the kitchenette and both w/c brakes were observed locked on the w/c. At 8:55 a.m. NA-C unlocked both brakes and brought R32 in the living room area, NA-C had wiped R32's face with a kleenex and covered the resident with a blanket, locked both brakes on the w/c and walked away. At 12:07 p.m. R32 was seated in his w/c at the counter in the kitchenette area, with both w/c braked observed locked. At 12:19 p.m. LPN-A sat down next to R32 and assisted him to eat his pears for dessert. Both w/c brakes remained in the locked position. At 12:13 p.m. R32 remained seated in a w/c with both brakes in the locked position at the counter in the kitchenette area. During observation on 3/16/16, at 7:45 a.m., R32 was seated at the counter by the kitchenette and the both w/c brakes were observed locked on the resident's w/c. R32 remained seated in the w/c with both brakes locked until 8:43 a.m., when staff assisted R32 into the tub room for cares. During observation on 3/17/16, at 7:58 a.m. R32 was seated in his w/c at the counter by the kitchenette and both brakes were observed to be locked on his w/c. During an interview on 3/16/17, at 9:07 a.m. nursing assistant (NA-A) stated R32 required extensive assistance with his care and indicated R32 would propel occasionally himself around the unit a little bit in his w/c. NA-A stated R32 would roll himself around in his w/c with his feet and stated she had not ever seen R32 apply the w/c	2 510		

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2 510	Continued From page 4 brakes independently. During interview on 3/17/16, at 1:31 p.m. registered nurse (RN-A) confirmed R32's current care plan and stated R32 required one assist for all of his cares unless there were behavior issues then the resident required 2 staff assist. RN-A stated R32 would walk from his bed to the bathroom with a walker, gait belt and sometimes would do a pivot transfer by his bed with staff assist. NA- A stated R32 used a w/c and staff would bring R32 from his room to his table for meals and the commons area .NA-A stated R32 can move his w/c around a little with his feet but needed help with pathfinding. NA-A stated R32 would not move himself in his w/c by himself from room to room but would move himself in his w/c a few feet in any direction. RN-A stated if R32 was seated at the counter, he may move his w/c back and forth from the counter during meal times. RN-A stated she thought the w/c brakes were used on R32's w/c only when he was transferred and couldn't think of any other time the brakes would be used. RN-A stated she was unsure if R32 could apply the w/c brakes independently. RN-A stated if a resident was unable to unlock the w/c brakes themselves then the brakes would be considered a restraint. During interview on 3/17/16, at 2:09 p.m., the director of nursing (DON) stated R32 had severe cognitive impairment, utilized a w/c, but thought he was unable to propel himself in the w/c. The DON stated R32 probably would not use the brakes on his w/c independently. The DON stated if a resident was placed in the middle of a room and the w/c brakes were locked, this would be considered a restraint for the resident. Review of the policy titled Resident Physical	2 510		

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2 510	Continued From page 5 Restraint with a review date of 10/5/15, indicated the facilities goal was to maximize the residents independence, functional capacity and their quality of life. Each resident had the right to be free of physical restraints imposed for discipline,convenience and not required to treat the residents medical symptoms. The policy further stated that the least restrictive measures are used and physical restraint usage be kept at a minimum. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could review the policies and procedures on the appropriate use of physical restraints. All appropriate staff could be educated on the process of appropriate use of physical restraints. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days	2 510		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents rooms were kept in good repair for 9 out of 75 residents rooms (rm 166, rm 118, rm 164, rm	21665	Corrected	4/26/16

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21665	Continued From page 6 119, rm 159, rm 104, rm 163, rm 172, rm 161) which had damaged doors, door frames, furniture and discolored rings around the base of toilets reviewed during the environmental tour. Findings Include: A environmental tour was conducted with the maintenance director (MD) on 3/17/16 at 9:35 a.m. and the MD verified the following findings: -Room 166's bathroom at the base of the toilet there was a brown colored substance around the ensure base of the toilet. - Room 118's bedroom there was a scrape on the lower right side of the room door. In addition, there was an area where paint was scraped off of the wall at the front of the residents bed. -Room 164's inside and the outside of the resident's bathroom door frame had multiple paint chips on it. -Room 119's lower portion of the resident's bathroom door had multiple scrapes on it. -Room 159's dresser and the closet had several chips in the wood work. -Room 104's lower portion of the inside of the resident's bathroom door and on the inside of the connecting rooms bathroom door had scrapes on them. -Room 163's bathroom at the base of the toilet there was a brown colored substance around it and the heater in the bathroom had areas were the register was rusty in color.	21665		

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21665	Continued From page 7 -Room 172's bathroom at the base of the toilet there was a brown colored substance around it. - Room 161's closet door had a large chip of wood missing from it, the second closet in the room had scratches in it. The inside of the resident's bathroom door was scraped and the base of the toilet had a brown colored substance around it During the environmental tour the MD stated he was not aware of the all of the above room issues. The MD stated he was unable to identify what brownish colored substance was present around all of the bases of the toilets, confirmed the rusty room heater and indicated the chips, scrapes and missing woodwork could of been caused from frequent rubbing of the wheelchairs, resident lifts utilized in the facility. The MD indicated when a resident room was empty and not filled right away, they would check the room. In addition, the MD stated the facility had no system in place to check for chipping paint, wood scratches, scratch paint on the doors or call lights and lights working in the facility. On 3/17/16, at 11:10 a.m. the maintenance man (M-A) verified he didn't go into rooms to spot check unless he was checking a water temperature in the room. The M-A stated there was a sign by the break room and staff would write down repairs that were needed. The M-A stated he felt the nurses and housekeeping would tell him if something would need repair. Review of the Maintenance Repair Log and Check list from 1/28/16 to 3/11/16 didn't identify any of the above resident's room issues. Review of the policy titled Physical Environment	21665		

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21665	Continued From page 8 Safe and Clean Environment with no date on it indicated the facility was to provide a safe,clean comfortable and homelike environment. The policy identified different items to be checked such as checking door frames, check window sills for worn varnish,splinters and cracks but lack the frequency the items were to be checked. SUGGESTED METHOD OF CORRECTION: The Maintenance Director (MD) could review and revise the policies, educate maintenance staff and identify trends of repeated building disrepair. The MD could work with the Director of nursing (DON) to ensure staff are reporting environmental issues appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		