DEPARTMENT OF HEALTH AND HUMAN SERVICES					CENTERS FOR MEDICARE & MEDICAID SERVICES			
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: 7XMX		
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00654		
1. MEDICARE/MEDICAID PROVIDE (L1) 245262	R NO.	3. NAME AND AL (L3) WEST WIN		CILITY		 TYPE OF ACTION: <u>7</u> (L8) Initial Recertification 		
2.STATE VENDOR OR MEDICAID N (L2) 482343500	0.	(L4) 1001 SCOT (L5) MORRIS, M			(L6) 56267	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint 			
6. DATE OF SURVEY 05/02/	2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of T	he Following Requirements:		
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit		
		· ·			3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	80 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SNI	 F)8. Patient Room Size 9. Beds/Room 		
13.Total Certified Beds	80 (L17)	B. Not in Comp	6		5. Life Safety Code			
		Requirements	and/or Applied	Waivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDON		ICE	IID		15. FACILITY MEETS	(115)		
18 SNF 18/19 SNF 80	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA			NCELLATION	DATE).				
10. STATE SURVET ADENCT REMIP	ikks (if Aff Lier		MCLLLAHON	DAIL).				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Gail Anderson, Unit Sup	ervisor	0	05/16/2016	(L19)	Mark Meath, Enforcement Specialist 06/06/2016 (L20)			
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	. ,	OFFICE OR SINGLE ST			
19. DETERMINATION OF ELIGIBILI	TY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to Pa	articipate	RIGH	HTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	_							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 09/01/1983	BEGINNINC	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburser	ment 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)			(L44)			00-Active		
(L27)	B. Rescind St	uspension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		03001						
	(L28)	00001		(L31)				
		DETERMENT		DATE				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 05/09/2016	OF APPROVAL	DALE				
	(L32)	05/07/2010		(L33)	DETERMINATION APPR	OVAL		



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



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,

Mart meeth

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF REVISI	Т
	5				
245262 _{Y1}	B. Wing	Y	2	5/2/2016	Y3
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	
¥4	15	14	10	14	15	
ID Prefix F0221	Correction	ID Prefix F0465	Correction	ID Prefix	Correctio	on
483.13(a)	Completed	Reg. #	(h) Completed	Reg. #	Complete	ed
LSC	04/11/2016		04/26/2016	LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correctic	วท
Reg. #	Completed	Reg. #	Completed	Reg. #	Complete	ed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correctio	วท
Reg. #	Completed	Reg. #	Completed	Reg. #	Complete	ed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correctic	วท
Reg. #	Completed	Reg. #	Completed	Reg. #	Complete	ed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correctio	on
Reg. #	Completed	Reg. #	Completed	Reg. #	Complete	ed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GA/mm	DATE 05/16/2016	SIGNATURE OF SURVEYOR 280)34	DATE 05/02/2016	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVE 3/17/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN TED DEFICIENCIES (CMS-2567)			b

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	E OF REVIS 9/2016	SIT Y3
NAME OF FACILITY WEST WIND VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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	DATE	ITEM	DATE	ITEM	DATE	
Y4	Y5	Y4	Y5	Y4	Y5	
ID Prefix	Correction	ID Prefix	Correctio	n ID Prefix	Correct	tion
NFPA 101 Reg. #	Completed	Reg. #	Complete	ed Reg. #	Comple	eted
LSC K0062	04/26/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Correctio	n ID Prefix	Correct	tion
Reg. #	Completed	Reg. #	Complete	ed Reg. #	Comple	eted
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correctio	n ID Prefix	Correct	tion
Reg. #	Completed	Reg. #	Complete	ed Reg. #	Comple	eted
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correctio	n ID Prefix	Correct	tion
Reg. #	Completed	Reg. #	Complete	ed Reg. #	Comple	eted
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correctio	n ID Prefix	Correct	tion
Reg. #	Completed	Reg. #	Complete	ed Reg. #	Comple	eted
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) TL/mm	DATE 05/16/2016	SIGNATURE OF SURVEYO 3476		DATE 04/29/2016	
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/14/2016			R ANY UNCORRECTED DEFI CTED DEFICIENCIES (CMS-2			NO

POST-CERTIFICATION REVISIT REPORT

				DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building 02 - POD			1	
245262 y1	B. Wing		Y2	4/29/2016	Y3
			12	L	
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			ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
		10	17		10	14		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
NFPA 10 Reg. #	1	Completed	Reg. #		Completed	Reg. #		Completed
LSC K0062		04/26/2016	LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		_	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		_	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		_	LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC		_	LSC			LSC		_
REVIEWED BY STATE AGENCY		WED BY LS) _{TL/mm}	DATE 05/16/2016	SIGNATURE OF	SURVEYOR 34764		DATE 04	/29/2016
REVIEWED BY CMS RO		WED BY LS)	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?						

MEDICARE/MEDICALID CERTIFICATION AND TRANSMITTAL PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY Bio: 7XMX Facility 10: 00654 1. MEDICARE/MEDICALD PROVIDER NO. (1.1) 245262 3. NAME AND ADDRESS OF FACILITY (1.3) WEST WIND VILLAGE (1.4) 1001 SCOTTS AVENUE 4. TYPE OF ACTION: 2_(1.8) (1.4) 1001 SCOTTS AVENUE 1. Initial 2. Recertification 3. Termaination 4. CHOW S Validation 6. Complaint 2.STATE VENDOR OR MEDICALD NO. (1.9) (1.6) MORRIS, MN (1.6) 56267 8. CRECITION ADDRESS OF FACILITY (1.3) WEST WIND VILLAGE 1. Initial 2. Recertification 3. Termaination 4. CHOW S Validation 6. Complaint 6. DEFECTIVE DATE CHANGE OF OWNERSHIP (19) (1.6) MORRIS, MN (1.6) 56267 8. Full Survey After Complaint 6. DEFECTIVE DATE CHANGE OF OWNERSHIP (19) 0. SINERFEDUAL 0. FRIFE 0 10 Integrated 0. FRIFE 10 FF 14 CORF 8. Full Survey After Complaint 6. ACCREDITIATION STATUS: (10) 0.01/FZ 200A 0.30/FZ 0.01/FZ 00 FRIFE 10 SNER 0.01/FZ 200A 6. SOPO of Services Limit 10. LICE DERIDEA OF CERTIFICATION (1. LICE DERIDEA CHIFICATION A. In Compliance with Program Requirements Compliance with Program Requirements and/or Applied Waivers: A. InCOMPLIANCE WITH PORTAL (2.3) 2.4 HOUR RN 6. SOPO of Services Limit (2.3) 2.4 HOUR RN 7. Medical Director 1. LICE CERTIFIED BED BREAKDOWNI 1. LICE CERTIFIED BED REAKDOWNI 1. STATE SURVEY AGENCY REMARKS (F APPLICABLE SHO	DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES			
1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (18) (1.1) 245262 (14) 1001 SCOTTS AVENUE 4. TYPE OF ACTION: 2 (18) (1.2) 48234500 (1.4) 1001 SCOTTS AVENUE 3. Termination 4. (HOW (1.2) 48234500 (1.5) MORRIS, MN (1.6) 56267 5. Effective Date CHANGE OF OWNERSHIP 0. Hoopital 0.5 MORRIS, MN (1.6) 5. CHARCE OF SURVEY 0.3/17/2016 (1.34) 0.5 SNFNF/Dual 0.9 FRF 10 NF 14 core 8. Full Survey After Complaint 0. Unaccediat 1 TLC 0.1 Hoopital 0.6 NFNF 10 NF 14 core 6. Scope of Services Limit 0.10 0.1 Certified Beds 80 (1.17) 10. THE FACILITY IS CERTIFIED AS: - A. IC Compliance With And/Or Approved Waivers Of The Following Requirements: 12. Total Facility Beds 80 (1.18) 10. Soft Compliance with Program - 5. Life Safety Code - 9. Beds/Room 12. Total Facility Beds 80 (1.37) (1.38) (1.39) (1.42) (1.43) 15. FACLITY MEETS 18. TATE SURVEY AGENCY APPROVAL 0.12)<				ID: 7XMX		
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	PART I -	TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 00654		
2.STATE VENDOR ON MEDICAID NO. (L4) 1001 SCOTTS AVENUE 3. Ternination 4. CHOW (L2) 48234350 (L5) MORRIS, MN (L6) 56267 5. Mornington 5. Complaint 6. Complaint 6. Complaint 7. On-Site Vist 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02_{-} (L7) 01 Hospital 09 ESR0 13 PTIP 22 CLIA 8. Full Survey After Complaint 6. DATE OF SURVEY 03/17/2016 (L34) 02 SNF/NF/Distine 07 X-Ray 11 IC/F/IID 15 ASC 96/30 0 Unaccredited 1 TUC 03 SNF/NF/Distine 07 X-Ray 11 IC/F/IID 15 ASC 06/30 06/30 10. THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: 06/30 -7. Medical Director -3. 24 Hour RN -7. Medical Director 12. Total Facility Beds 80 (L17) X B. Not in Compliance with Program Requirements and/or Applied Waivers: And/Or Approved Waivers: * Code: -5. Life Safety Code -9. Beds/Room 13. Total Certified Beds 80 (L17) X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12) <td></td> <td>(L3) WEST WIND VILLAGE</td> <td></td> <td></td>		(L3) WEST WIND VILLAGE				
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint 6. DATE OF SURVEY 03/17/2016 (L34) 05 HHA 09 ESRD 13 PTIP 22 CLA 8. Full Survey After Complaint 6. DATE OF SURVEY 03/17/2016 (L34) 05 NF/NF/Distinet 07 X-Ray 11 CF/IID 15 ASC FISCAL YEAR ENDING DATE: (L35) 0 Unaccredited 1 TIC			(L6) 56267	3. Termination4. CHOW5. Validation6. Complaint		
8. ACCREDITATION STATUS:						
2 AOA 3 Other INT				FISCAL YEAR ENDING DATE: (L35)		
From (a): A. In Compliance With And/Or Approved Waivers Of The Following Requirements: To (b): Program Requirements Compliance Based On: 6. Scope of Services Limit 12.Total Facility Beds 80 (L18)		04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	06/30		
To (b): Program Requirements Compliance Based On: 2. Technical Personnel 6. Scope of Services Limit 12.Total Facility Beds 80 (L18) 1. Acceptable POC 4. 7-Day RN (Rural SNF) 8. Patient Room Size 13.Total Certified Beds 80 (L17) X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12) 14. LTC CERTIFIED BED BREAKDOWN IS. SATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): IS. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Date: 18. STATE SURVEY AGENCY APPROVAL Date:	11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
12.Total Facility Beds 80 (L18) 13.Total Certified Beds 80 (L17) 14. LTC CERTIFIED BED BREAKDOWN Image: Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12) 14. LTC CERTIFIED BED BREAKDOWN Image: Compliance With Program Requirements and/or Applied Waivers: * Code: B* (L12) 14. LTC CERTIFIED BED BREAKDOWN Image: Compliance With Program Requirements and/or Applied Waivers: * Code: B* (L12) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Image: Compliance With Program Requirements and/or Date: Image: Code: Image: Code: Image: Code: 17. SURVEYOR SIGNATURE Date : Image: Code: Image: Code: Image: Code: Image: Code:	From (a):	A. In Compliance With	And/Or Approved Waivers Of T	The Following Requirements:		
12. Total Facility Beds 80 (L18) 13. Total Certified Beds 80 (L17) X B. Not in Compliance with Program Requirements and/or Applied Waivers: - 14. LTC CERTIFIED BED BREAKDOWN X 18 SNF 18/19 SNF 18/19 SNF 19 SNF 19. CF IID 10. CTAT 10. TCF 10. CTAT 10. TCF 11. Acceptable POC - 11. Acceptable POC - 12. Total Sold 11. Acceptable POC 13. Total Certified Beds Not in Compliance with Program Requirements and/or Applied Waivers: 14. LTC CERTIFIED BED BREAKDOWN 10. FCF 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date :	To (b) :		2. Technical Personnel	6. Scope of Services Limit		
12. Total Facility Beds 80 (L18)		Compliance Based On:	3. 24 Hour RN	7. Medical Director		
13. Total Certified Beds 80 (L17) X B. Not in Compliance with Program Requirements and/or Applied Waivers: -5 . Life Safety Code -9 . Beds/Room 14. LTC CERTIFIED BED BREAKDOWN Requirements and/or Applied Waivers: $* Code:$ $B*$ (L12) 14. LTC CERTIFIED BED BREAKDOWN 19 SNF 19 SNF ICF IID 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Ia. STATE SURVEY AGENCY APPROVAL Date: 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date:	12 Total Facility Beds 80 (I 18)	1. Acceptable POC	4. 7-Day RN (Rural SNI	F) 8. Patient Room Size		
Requirements and/or Applied Waivers: * Code: B* (L12) 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 18. STATE SURVEY MEETS 1861 (e) (1) or 1861 (j) (1): (L15) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 18. STATE SURVEY AGENCY APPROVAL Date:	-	X P Not in Compliance with Program	5. Life Safety Code	9. Beds/Room		
14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15) 80 (L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date:			* Code: B *	(L12)		
18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15) 80 (L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 18. STATE SURVEY AGENCY APPROVAL Date:	14. LTC CERTIFIED BED BREAKDOWN					
80 (L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):		ICF IID	1861 (e) (1) or 1861 (i) (1):	(L15)		
(L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date:						
17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date :	(L37) (L38) (L39)	(L42) (L43)				
17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date :	16 STATE SURVEY AGENCY REMARKS (IF APPLIC)	BLE SHOW LTC CANCELLATION DATE)				
17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date: 17. SURVEYOR SIGNATURE Date : 19. STATE SURVEY AGENCY APPROVAL Date:						
	17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:		
'Tammy Williams, HFE NEII04/21/2016Enforcement Specialist05/02/2016	'Tammy Williams, HFE NEII		Enforcement Specialist			
(L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY	PART II - TO BE		OFFICE OR SINGLE ST	· · ·		
RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 			
X 1. Facility is Eligible to Participate 3. Both of the Above :			3. Both of the Above	:		
2. Facility is not Eligible (L21)	2. Facility is not Eligible (L21)					
22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30)	22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY 00 INVOLUNTARY 09/01/1983 01-Merger, Closure 05-Fail to Meet Health/Safety		G DATE ENDING DATE				
(L24) (L41) (L25) 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	(L24) (L41)	(L25)				
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 03-Risk of Involuntary Termination OTHER	25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS	03-Risk of Involuntary Termination	1 <u>OTHER</u>		
A. Suspension of Admissions: 04-Other Reason for Withdrawal 07-Provider Status Change	A. Suspensio	n of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change		
(L44) 00-Active	(1.27)			00-Active		
B. Resenid Suspension Date.	(L27) B. Rescind S					
(L45)	29 TEDMINIATION DATE. 24		20 DEMARKS			
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS	28. TERMINATION DATE: 25		30. REMARKS			
03001						
(L28) (L31)	(L28)	(L31)				
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE	31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION OF APPROVAL DATE				
(L32) (L33) DETERMINATION APPROVAL	(L32)	(L33)	DETERMINATION APPR	OVAL		



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

		AND HUMAN SERVICES			FORM	APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	<u>/IB NO.</u>	0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		DATE SURVEY	
		245262	B. WING		03 / [.]	17/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WEST W	IND VILLAGE			1001 SCOTTS AVENUE			
				MORRIS, MN 56267			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	ſS	F 000				
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 221 SS=D	on-site revisit of you validate that substa regulations has bee your verification.		F 221			4/11/16	
	physical restraints i	e right to be free from any mposed for purposes of nience, and not required to medical symptoms.					
	by: Based on observat review the facility fa identified and asses residents (R32) with wheelchair.	NT is not met as evidenced ion, interview and document iled to ensure a restraint was ssed for use for 1 of 1 n locked brakes on the		Wheelchair brakes were unlocked a will be kept unlocked for resident 32 32 can propel own wheelchair. With exception of transferring residents, s will keep all resident wheelchair brail unlocked.	2, so R n the staff		
	2/24/16, indicated F required extensive a had utilized a whee	num Data Set (MDS) dated R32 was severely impaired, assistance of 2 to transfer and I chair (w/c). R32 had cluded Alzheimer's disease		The Resident Physical Restraint Pol was reviewed and updated as neces to include locking resident wheelcha brakes as an example of a restraint. All staff will be educated on the resid	ssary air		
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	
Electron	ically Signed					04/05/2016	

Electronically Signed

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

PRINTED: 04/21/2016

		AND HUMAN SERVICES				FORM	: 04/21/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245262	B. WING			03 / [.]	17/2016
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	IND VILLAGE				001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	2/24/16, indicated F ambulate independ wished to. In addition transferred manual lift) due to the resid R32 continued to be a gait belt and had depending on the re- mobile in his w/c ar resident with pathfin which included bein aggressive, agitation R32's care plan wit revealed R32 requi when using Pal lift (transfers). The care risk for falls related assist as needed w required assistance care plan did not ac brakes for R32.	aring loss. ment Area (CAA) dated R32 was able to transfer and ently when the resident on, R32 was generally ly or mechanically (mechanical ent's cognition and behaviors. e an assist of 2 to 3 staff with used a walker for ambulation esident's behaviors. R 32 was not the staff would assist the nding. R32 had behaviors og physically and verbally on, yelling and spitting. h a print date of 3/17/16, red 1 to 2 to transfer and 2 (mechanical device used for e plan identified R32 was at to cognitive deficits, required ith mobility and transfers, and e with mobility in the w/c. medical record was reviewed	Fź	221	DEFICIENCY) Physical Restraint Policy. Random audits of w/c brakes are conducted to assess if resident w/c brakes are being locked and hinder them from propelling own w/c by th DON/designee 3 times a week for 4 weeks, 2 times a week for 4 weeks then weekly. Audit results will be br to the QAPI committee for further recommendations. Date of completion: 4/15/16	ring e 4 s and	
	the medical record During continuous 4:54 p.m., R32 was front of the kitchene was seated in his w observed locked ar the w/c. R32 was o back and forth in hi reached down and	e of a restraint assessment in or the MDS. observation on 3/14/16, at seated at the counter area in ette waiting for supper. R32 v/c, both w/c breaks were nd R32 was unable to move bserved to be rocking himself s w/c seat. At 5:56 p.m. NA-B unlocked R32's brakes on the nto the living area and reached					

Facility ID: 00654

If continuation sheet Page 2 of 8

		AND HUMAN SERVICES				FORM	04/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245262	B. WING			03/-	17/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	VIND VILLAGE				001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	down and locked bo was trying to scoot i unable to move the remained seated in locked, a staff mem handed the residen away. At 6:28 p.m. w/c with both brake During observation was observed seate kitchenette and both locked on the w/c. A both brakes and bro area, NA-C had wip and covered the resident both brakes on the At 12:07 p.m. R32 with braked observed loo down next to R32 a pears for dessert. Be the locked position. seated in a w/c with position at the count During observation was seated at the c the both w/c brakes resident's w/c. R32 with both brakes loo staff assisted R32 in During observation was seated in his w	oth brakes on the w/c. R32 forward in his w/c but was w/c. At 6:01 p.m., R32 the w/c with both brakes ober walked up to R32 and t a music book and walked R32 remained seated in the	F 2	221			

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		AND HUMAN SERVICES				FORM	04/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245262	B. WING			03/	17/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	/IND VILLAGE				001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	During an interview nursing assistant (N extensive assistant R32 would propel o unit a little bit in his roll himself around i stated she had not brakes independent During interview on registered nurse (R care plan and state all of his cares unle then the resident re stated R32 would w bathroom with a wa would do a pivot tra assist. NA- A stated would bring R32 fro meals and the com can move his w/c a needed help with pa would not move hin from room to room w/c a few feet in an was seated at the c back and forth from times. RN-A stated were used on R32's transferred and cou the brakes would be unsure if R32 could independently. RN- unable to unlock the the brakes would be During interview on director of nursing (on 3/16/17, at 9:07 a.m. NA-A) stated R32 required be with his care and indicated be casionally himself around the w/c. NA-A stated R32 would in his w/c with his feet and ever seen R32 apply the w/c	F 2	221			

Facility ID: 00654

If continuation sheet Page 4 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245262	B. WING			03 / ⁻	17/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	IND VILLAGE			-	001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221 F 465 SS=E	DON stated R32 pri brakes on his w/c iri if a resident was pla and the w/c brakes considered a restra Review of the policy Restraint with a rev the facilities goal wa independence, func quality of life. Each free of physical rest discipline, convenier the residents medic further stated that th are used and physic a minimum. 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review the facility fa rooms were kept in residents rooms (rm 119, rm 159, rm 104 which had damaged and discolored rings	opel himself in the w/c. The obably would not use the idependently. The DON stated aced in the middle of a room were locked, this would be int for the resident. v titled Resident Physical few date of 10/5/15, indicated as to maximize the residents tional capacity and their resident had the right to be raints imposed for nce and not required to treat al symptoms. The policy ne least restrictive measures cal restraint usage be kept at L/SANITARY/COMFORTABL	F 2		Environmental Services' Preventive Maintenance Policy for the general fa and resident rooms was evaluated a updated. West Wind Village added a "Daily Checklist" for the general facility and "Quarterly Checklist" for resident roo as well as, quarterly audits of reside	e facility and d a poms,	4/26/16

Facility ID: 00654

If continuation sheet Page 5 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED								
		& MEDICAID SERVICES					0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED	
		245262	B. WING _			03 /1	7/2016	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WEST W	IND VILLAGE				001 SCOTTS AVENUE			
				M	IORRIS, MN 56267			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 465	Continued From pa	ae 5	F 4	65				
	Findings Include:	900		00	rooms.			
	maintenance directa a.m. and the MD ver -Room 166's bathro there was a brown of ensure base of the - Room 118's bedro lower right side of the there was an area we the wall at the front -Room 164's inside resident's bathroom chips on it. -Room 119's lower bathroom door had -Room 159's dresse chips in the wood we -Room 104's lower resident's bathroom connecting rooms be them. -Room 163's bathroom	om there was a scrape on the ne room door. In addition, where paint was scraped off of of the residents bed. e and the outside of the a door frame had multiple paint portion of the resident's multiple scrapes on it. er and the closet had several rork. portion of the inside of the a door and on the inside of the bathroom door had scrapes on pom at the base of the toilet colored substance around it			Maintenance staff will be educated these new policies and how to use daily and quarterly checklists. All si be educated, at an all staff inservice how to report maintenance concern problems by either contacting maintenance directly (if it is urgent) recording it on the maintenance rep The resident bathrooms in rooms 1 163, 166 and 172 will have the brow substance around the base of the to removed by maintenance staff. The scrapes, scratches and chippe will be repaired on closet doors, bat doors, resident room doors and furn in resident rooms 104, 118, 119, 15 and 164. These rooms will also has paint scrapes and chips on walls an frames repaired and touched up. T concerns with the heater in the bath in room 163 will be corrected. Resident rooms starting with the part of the building and repairs will 1 made as identified on the audits by maintenance personnel.	the taff will e, on is or or pair log. 61, vn oilet d wood throom niture 9, 161, ve all nd door he nroom cted in oldest be		
	the register was rus	oom at the base of the toilet			Going forward, all resident rooms w audited quarterly (27 rooms per mo and the results will be reviewed at V Wind Village's quarterly QAPI meet monitor and identify tronds	onth) Nest		
		colored substance around it. t door had a large chip of			monitor and identify trends. Daniel Kittleson, Environmental Ser	rvices		

PRINTED: 04/21/2016

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245262	B. WING		03/ [.]	17/2016
NAME OF F	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	/IND VILLAGE			001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	wood missing from room had scratches resident's bathroom base of the toilet ha around it During the environm was not aware of th issues. The MD sta what brownish colo around all of the ba the rusty room hea scrapes and missin caused from freque resident lifts utilized indicated when a re- not filled right away In addition, the MD system in place to o scratches, scratch and lights working i On 3/17/16, at 11:1 (M-A) verified he d check unless he wa temperature in the was a sign by the b write down repairs stated he felt the nu- tell him if something Review of the Main Check list from 1/20 any of the above re- Review of the polici Safe and Clean Em- indicated the facility	it, the second closet in the s in it. The inside of the n door was scraped and the ad a brown colored substance mental tour the MD stated he he all of the above room ated he was unable to identify ored substance was present ases of the toilets, confirmed ater and indicated the chips, ng woodwork could of been ent rubbing of the wheelchairs, d in the facility. The MD esident room was empty and v, they would check the room. stated the facility had no check for chipping paint, wood paint on the doors or call lights	F 465	Director will monitor for compliance	s.	

If continuation sheet Page 7 of 8

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/21/2016 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245262	B. WING			03/ ⁻	17/2016
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	/IND VILLAGE				001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	policy identified diff such as checking d for worn varnish,sp	age 7 Ferent items to be checked door frames, check window sills linters and cracks but lack the s were to be checked.	F 4	465			

If continuation sheet Page 8 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	75	a and	FORM	04/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>	LTIPL	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245262	B, WING			03/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	*		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	IND VILLAGE				001 SCOTTS AVENUE IORRIS, MN 56267		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
K 000	INITIAL COMMENT	ſS	ĸ	000			
	FIRE SAFETY	ΞΤΥ			-		
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.					
	Minnesota Departm time of this survey, NOT in substantial requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			•2		
	DEFICIENCIES (K-TAGS) TO: Health Care Fire Ins State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	R THE FIRE SAFETY spections Division Suite 145			EPOC		4
	By email to:						
	r DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 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.

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT			. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG 01 - MAIN BUILDING 01		MPLETED
		245262	B. WING			/14/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
NEST W	IND VILLAGE			1001 SCOTTS AVENUE MORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
K 000	Angela.Kappenma <mailto:angela.kap< td=""><td>state.mn.us hitney@state.mn.us> and</td><td>κo</td><td>00</td><td>-3</td><td></td></mailto:angela.kap<>	state.mn.us hitney@state.mn.us> and	κo	00	-3	
	 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 					
	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.					
		prinkler system is installed				

PRINTED: 04/11/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		•	X3) DATE SURVEY COMPLETED
				01 - MAIN BUILDING 01	
		245262	B. WING		03/14/2016
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
EST W	IND VILLAGE			001 SCOTTS AVENUE NORRIS, MN 56267	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 000	Continued From pa	ige 2	K 000		
	Systems (1999 edit alarm system with a down the corridors smoke detection in in all the sleeping re Additional automati all rooms required I Code. The fire alarn fire department not building and the ad types required and by an automatic fire was surveyed as on capacity of 80 beds time of the survey.	Installation of Sprinkler tion). The building has a fire automatic smoke detectors with additional automatic all common use spaces and boms of the 1999 additions. c fire detection is provided in by the Minnesota State Fire m is monitored for automatic ification. Because the original ditions meet the construction the entire facility is protected e sprinkler system the facility he building. The facility has a and had a census of 78 at the			
K 062 SS=D	NOT MET as evide NFPA 101 LIFE SA Required automatic continuously mainta condition and are in periodically. 19.7 9.7.5	FETY CODE STANDARD c sprinkler systems are ained in reliable operating hspected and tested (.6, 4.6.12, NFPA 13, NFPA 25	K 062		4/26/16
	Required automati continuously mainta condition and are in	s not met as evidenced by: c sprinkler systems are ained in reliable operating hspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25		West Wind Village has scheduled a area sprinkler company to perform the five year maintenance check of the facility⊔'s sprinkler system in order t maintain the internal piping and gaug	he :o
	Findings include:			This inspection is scheduled for Apri 2016.	120,
	During documentat	ion review on 03/14/2016		Daniel Kittelson, Environmental Serv	

Event ID: 7XMX21

Facility ID: 00654

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES			FORM	04/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245262	B. WING		03/	14/2016
	PROVIDER OR SUPPLIER	ļ		STREET ADDRESS, CITY, STATE, 1001 SCOTTS AVENUE MORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O	TION SHOULD BE	(X5) COMPLETION DATE
K 062	on 06/11/2008.	ige 3 heck that could be found was s verified by Environmental	κo		sure that the perly serviced to	
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: 7XMX2	21	Facility ID: 00654	If continuation she	et Page 4 of 4

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	PLE CONSTRUCTION G 02 - POD		TE SURVEY MPLETED
		245262	B. WING		03	/14/2016
IAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
VEST W	IND VILLAGE			1001 SCOTTS AVENUE MORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMENT	rs	K 00	0		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio time of this survey, called "The Pod" of Center was found the the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 19	Survey was conducted by the nent of Public Safety, State on, on March 14, 2016. At the the wing that was added the West Wind Village Care to be NOT in compliance with or participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care Occupancies.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY		EPO	C	
	Health Care Fire In: State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145				

Electronically Signed

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 patients. program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 02 - POD	(X3) DATE SURVEY COMPLETED	
		245262	B. WING		03/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WEST W	IND VILLAGE			1001 SCOTTS AVENUE MORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 00	00		-
24	Angela.Kappenmar	itney@state.mn.us> and				
		RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION:				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.		-		
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency				
	Care Carenter cons addition and is one basement, is fully fi	dition 02 of West Wind Village sists of a 2015 building story in height, has no re sprinkler protected and was f Type II (000) construction.				
	detection in the cor corridors which is n department notifica	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a and the census was 78 at the		ικ:		
K 062 SS=D	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 0	62		4/26/16
		systems are continuously le operating condition and are				

Event ID:7XMX21

Facility ID: 00654

If continuation sheet Page 2 of 3

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · · /	IPLE CONSTRUCTION		TE SURVEY
		245262	B. WING			14 4 12 0 4 6
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		3/14/2016
NEOTIN				1001 SCOTTS AVENUE		
WEST W	IND VILLAGE			MORRIS, MN 56267		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
K 062	4.6.12, NFPA 13, N This STANDARD i Automatic sprinkle maintained in reliat	ed periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 s not met as evidenced by: r systems are continuously ble operating condition and are ed periodically. 18.7.6, 19.7.6,	К 06	S2 Corrected		
	between 1330 and 1) Internal piping a maintained. Last c on 06/11/2008.	tion review on 03/14/2016 1700, revealed that: and gauges have not been heck that could be found was s verified by Environmental				

PRINTED: 04/11/2016



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00654	B. WING		03/1	7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WEST W	IND VILLAGE		TTS AVENU MN 56267	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	electronic receipt of consistent with the Health Informationa http://www.health.st obul.htm The Stat delineated on the M	FS: eed to participate in the f State licensure orders Minnesota Department of al Bulletin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are finnesota Department of				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 04/05/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00654	B. WING		03/17/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
VEST W	IND VILLAGE		OTTS AVENL , MN 56267	IE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
2 000	Health orders being Although no plan of State Statutes/Rule "corrected" in the b indicate in the elect under the heading orders will be corre	ge 1 submitted electronically. correction is necessary for es, please enter the word ox available for text. Then ronic State licensure process, completion date, the date your cted prior to electronically innesota Department of				
2 510	Subp. 2. Freedom must be free from a restraints imposed	O Subp. 2 Use of Restraints from restraints. Residents any physical or chemical for purposes of discipline or not required to treat the symptoms.	2 510			4/15/16
	by: Based on observati review the facility fa identified and asses	ent is not met as evidenced on, interview and document alled to ensure a restraint was ssed for use for 1 of 1 n locked brakes on the		Corrected		
	R32's annual Minim 2/24/16, indicated F required extensive had utilized a whee	num Data Set (MDS) dated R32 was severely impaired, assistance of 2 to transfer and I chair (w/c). R32 had cluded Alzheimer's disease aring loss.	1			
	2/24/16, indicated F	ment Area (CAA) dated R32 was able to transfer and ently when the resident				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00654	B. WING		03/	17/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
		1001 SC	OTTS AVENUE			
WEST W	IND VILLAGE		, MN 56267			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 510	Continued From pa	ae 2	2 510			
	transferred manual lift) due to the resid R32 continued to be a gait belt and had depending on the re mobile in his w/c ar resident with pathfin which included bein aggressive, agitatio R32's care plan with revealed R32 required when using Pal lift (transfers). The care risk for falls related assist as needed w required assistance	on, R32 was generally ly or mechanically (mechanica ent's cognition and behaviors. e an assist of 2 to 3 staff with used a walker for ambulation esident's behaviors. R 32 was not the staff would assist the nding. R32 had behaviors ng physically and verbally on, yelling and spitting. h a print date of 3/17/16, red 1 to 2 to transfer and 2 (mechanical device used for e plan identified R32 was at to cognitive deficits, required ith mobility and transfers, and e with mobility in the w/c. R32's ddress the use of the w/c				
	,	medical record was reviewed e of a restraint assessment in or the MDS.				
	4:54 p.m., R32 was front of the kitchene was seated in his w observed locked an the w/c. R32 was of back and forth in hi	observation on 3/14/16, at seated at the counter area in ette waiting for supper. R32 v/c, both w/c breaks were ad R32 was unable to move bserved to be rocking himself s w/c seat. At 5:56 p.m. NA-B unlocked R32's brakes on the				
	w/c, wheeled R32 in down and locked bo was trying to scoot unable to move the remained seated in	nto the living area and reached oth brakes on the w/c. R32 forward in his w/c but was w/c. At 6:01 p.m., R32 the w/c with both brakes nber walked up to R32 and	1			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00654	B. WING		03/	17/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
WEST W	IND VILLAGE		OTTS AVENUE , MN 56267	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 510	Continued From pa	ige 3	2 510			
		R32 remained seated in the solocked on his w/c.				
	was observed seate kitchenette and bot locked on the w/c. / both brakes and bro area, NA-C had wip and covered the res	on 3/15/16, at 8:52 a.m., R32 ed at the counter near the h w/c brakes were observed At 8:55 a.m. NA-C unlocked ought R32 in the living room bed R32's face with a kleenex sident with a blanket, locked w/c and walked away.				
	counter in the kitch braked observed lo down next to R32 a pears for dessert. E the locked position. seated in a w/c with	was seated in his w/c at the enette area, with both w/c ocked. At 12:19 p.m. LPN-A sat and assisted him to eat his Both w/c brakes remained in At 12:13 p.m. R32 remained of both brakes in the locked other in the kitchenette area.				
	was seated at the c the both w/c brakes resident's w/c. R32 with both brakes loo	on 3/16/16, at 7:45 a.m., R32 counter by the kitchenette and s were observed locked on the remained seated in the w/c cked until 8:43 a.m., when nto the tub room for cares.				
	was seated in his w	on 3/17/16, at 7:58 a.m. R32 //c at the counter by the h brakes were observed to be				
	nursing assistant (N extensive assistant R32 would propel o unit a little bit in his	on 3/16/17, at 9:07 a.m. NA-A) stated R32 required with his care and indicated occasionally himself around the w/c. NA-A stated R32 would in his w/c with his feet and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	00654 B. WING		B. WING		03/	17/2016	
NAME OF F	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SCOTTS AVENUE						
VEST W	IND VILLAGE		MN 56267				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 510	Continued From pa	age 4	2 510				
	brakes independen	itly.					
	registered nurse (R care plan and state all of his cares unlet then the resident re- stated R32 would w bathroom with a wa would do a pivot tra assist. NA- A stated would bring R32 fro- meals and the com can move his w/c a needed help with po- would not move him from room to room w/c a few feet in an was seated at the c back and forth from times. RN-A stated were used on R32's transferred and cou the brakes would b unsure if R32 could independently. RN- unable to unlock th the brakes would b	a 3/17/16, at 1:31 p.m. RN-A) confirmed R32's current ad R32 required one assist for ess there were behavior issues equired 2 staff assist. RN-A valk from his bed to the alker, gait belt and sometimes ansfer by his bed with staff d R32 used a w/c and staff om his room to his table for mons area .NA-A stated R32 around a little with his feet but athfinding. NA-A stated R32 mself in his w/c by himself but would move himself in his by direction. RN-A stated if R32 counter, he may move his w/c in the counter during meal she thought the w/c brakes s w/c only when he was uldn't think of any other time e used. RN-A stated she was d apply the w/c brakes A stated if a resident was e w/c brakes themselves then e considered a restraint.					
	director of nursing of cognitive impairment he was unable to p DON stated R32 pr brakes on his w/c in if a resident was pla	a 3/17/16, at 2:09 p.m., the (DON) stated R32 had severe nt, utilized a w/c, but thought ropel himself in the w/c. The robably would not use the independently. The DON stated aced in the middle of a room were locked, this would be atint for the resident.					
	Review of the polic						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00654	B. WING		03/	17/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
WEST W	IND VILLAGE		OTTS AVENU 6, MN 56267	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 510	Restraint with a rev the facilities goal we independence, fund quality of life. Each free of physical res discipline,convenie the residents medic further stated that t	view date of 10/5/15, indicated as to maximize the residents ctional capacity and their resident had the right to be	2 510			
	The Director of Nur review the policies appropriate use of appropriate staff co process of appropri The Director of Nur develop a monitorir compliance.	THOD OF CORRECTION: rsing or her designee could and procedures on the physical restraints. All build be educated on the iate use of physical restraints. rsing or her designee could ng system to ensure ongoing R CORRECTION: Fourteen				
	(14) days	A CORRECTION. Fourieen				
21665	MN Rule 4658.140	0 Physical Environment	21665			4/26/16
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.				
	by: Based on observati review the facility fa rooms were kept in	ent is not met as evidenced ion, interview and document ailed to ensure residents good repair for 9 out of 75 n 166, rm 118, rm 164, rm		Corrected		

7XMX11

If continuation sheet 6 of 9

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00654	B. WING		03/	17/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
WEST W	IND VILLAGE		OTTS AVENUE , MN 56267			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	ge 6	21665			
	which had damaged and discolored ring	4, rm 163, rm 172, rm 161) d doors, door frames, furniture s around the base of toilets e environmental tour.				
	Findings Include:					
	maintenance direct	ur was conducted with the or (MD) on 3/17/16 at 9:35 prified the following findings:				
		oom at the base of the toilet colored substance around the toilet.				
	lower right side of the there was an area v	oom there was a scrape on the he room door. In addition, where paint was scraped off of of the residents bed.				
		e and the outside of the n door frame had multiple paint	t			
		portion of the resident's multiple scrapes on it.				
	-Room 159's dress chips in the wood w	er and the closet had several ork.				
	resident's bathroom	portion of the inside of the a door and on the inside of the pathroom door had scrapes on				
	there was a brown	oom at the base of the toilet colored substance around it e bathroom had areas were sty in color.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00654	B. WING		03/	17/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
NEST W	VIND VILLAGE		OTTS AVENUE MN 56267			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	YTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	-Room 172's bathro	ige 7 oom at the base of the toilet colored substance around it.	21665			
	- Room 161's close wood missing from room had scratche resident's bathroon	et door had a large chip of it, the second closet in the s in it. The inside of the n door was scraped and the ad a brown colored substance				
	was not aware of the issues. The MD state what brownish color around all of the bat the rusty room hear scrapes and missin caused from freque resident lifts utilized indicated when a re- not filled right away In addition, the MD system in place to of	mental tour the MD stated he he all of the above room ated he was unable to identify red substance was present ases of the toilets, confirmed ater and indicated the chips, hg woodwork could of been ent rubbing of the wheelchairs, d in the facility. The MD esident room was empty and r, they would check the room. stated the facility had no check for chipping paint, wood paint on the doors or call lights in the facility.				
	(M-A) verified he d check unless he wa temperature in the was a sign by the b write down repairs stated he felt the nu	0 a.m. the maintenance man lidn't go into rooms to spot as checking a water room. The M-A stated there reak room and staff would that were needed. The M-A urses and housekeeping would g would need repair.				
	Check list from 1/2	tenance Repair Log and 8/16 to 3/11/16 didn't identify esident's room issues.				
	Review of the polic	y titled Physical Environment				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING		-	
		00654	B. WING		03/17/2016	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VEST W	IND VILLAGE		OTTS AVENUE , MN 56267	1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21665	Continued From pa	age 8	21665			
	indicated the facility comfortable and he policy identified diff such as checking of for worn varnish, sp frequency the items SUGGESTED MET Maintenance Direct revise the policies, and identify trends The MD could work (DON) to ensure st issues appropriated	avironment with no date on it y was to provide a safe,clean omelike environment. The ferent items to be checked door frames, check window sills olinters and cracks but lack the s were to be checked. THOD OF CORRECTION: The stor (MD) could review and educate maintenance staff of repeated building disrepair. k with the Director of nursing taff are reporting environmenta ly. R CORRECTION: Twenty-one)			