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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BNXZ

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) 03/21/2012

6. DATE OF SURVEY (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 IMR	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 **88** (L18)

13.Total Certified Beds **88** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:
* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	88			
(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):
Post certification revisit to verify that the facility has achieved and maintained compliance with Federal certification regulations. Please refer to the CMS 2567B for both health and life safety code. Effective March 16, 2012, the facility is certified for 88 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 04/12/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/12/2012 (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
Posted 4/172012 ML

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
03/26/2012 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5262 April 12, 2012

Mr. Michael Syltie, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

Dear Mr. Syltie:

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 March 24, 2012, the above facility is certified for:

88 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 88 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900 , St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 12, 2012

Mr. Michael Syltie, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

RE: Project Number S5262023

Dear Mr. Syltie:

On February 22, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 3, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 21, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 14, 2012 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 3, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 16, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 3, 2012, effective March 16, 2012 and therefore remedies outlined in our letter to you dated February 22, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245262	A. Building B. Wing	3/21/2012

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/16/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/16/2012**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/16/2012**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/16/2012**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0507** Reg. # **483.75(i)(2)(iv)** LSC	Correction Completed **03/16/2012**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/cbl	04/12/2012	18623	03/21/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/3/2012

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245262	01 - MAIN BUILDING 01	3/14/2012

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	03/05/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	04/12/2012	27200	03/14/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
1/31/2012	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BNXZ

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 **02/03/2012** (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 IMR	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 **88** (L18)

13.Total Certified Beds **88** (L17)

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

. 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	IMR
	88			
(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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post certification revisit to follow.

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 03/20/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 03/22/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 3/26/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8869

February 22, 2012

Mr. Michael Syltie, Administrator
West Wind Village
1001 Scotts Avenue
Morris, Minnesota 56267

RE: Project Number S5262023

Dear Mr. Syltie:

On February 3, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<u>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;

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
1645 Energy Park Drive, Suite 300
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 14, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 14, 2012, the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 3, 2012 (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 August 3, 2012 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

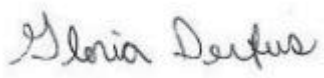
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

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

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 _____	02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND VILLAGE	1001 SCOTT'S 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the 2011 federal survey, fire marshal survey and plan of corrections were posted in area that was easily accessible to residents, family and visitors. This had the potential to affect all 83 residents in the facility. Findings include:	F 167	**F167C** Moved and labeled past survey results to a more public and resident accessible location. Will update as necessary and will inform residents at resident council of location. Will also send a letter to responsible parties of the location of past Survey results and we will also inform new admissions of the location. SW/Designee will audit 1x/week for 1 month, then monthly thereafter to ensure residents and responsible parties are being informed of new location of survey results. Audits will be brought to the QA committee for further recommendations. Completion Date: 3-16-12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-1-12

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 _____ B. WING _____	02/03/2012

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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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 2 - 2012 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the 2011 federal survey, fire marshal survey and plan of corrections were posted in area that was easily accessible to residents, family and visitors. This had the potential to affect all 83 residents in the facility. Findings include:	F 167	F167C Moved and labeled past survey results to a more public and resident accessible location. Will update as necessary and will inform residents at resident council of location. Will also send a letter to responsible parties of the location of past Survey results and we will also inform new admissions of the location. SW/Designee will audit 1x/week for 1 month, then monthly thereafter to ensure residents and responsible parties are being informed of new location of survey results. Audits will be brought to the QA committee for further recommendations. Completion Date: 3-16-12	

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

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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F 167	Continued From page 1 During the environment tour at 2:00 p.m. on 2/2/12, the 2011 survey results were noted to be posted in the entrance way vestibule between two automatic doors. The survey was placed in a clear plastic holder and was not labeled as to its contents. The administrator verified at that time that there was not a sign anywhere in the facility that informed resident, family and guest where the survey results were available to read. The administrator further verified the residents did not frequent the entrance vestibule.	F 167		
	During interview with R12 at 4:30 p.m. on 1/30/12, she was asked if she knew where to find the results for the survey. R12 was interviewed as a member of the resident council committee. R12 stated she was not aware that a report was left at the facility and was not aware where she could locate it. R12 stated, "If I were to guess, it is probably in the business office?" She stated no one had ever discussed the survey results or their location to her. R12 was identified by the facility as the representative of the resident council that would be appropriate for interviewing. She was identified as a reliable interview. During interview with R45 at 2:45 p.m. on 2/2/12, she stated she was not aware where the facility maintained the survey results. R45 was admitted to the facility on 12/28/11, and her admission assessment dated 1/9/12, identified her with intact cognition and identified she was free of mood or behavior indicators. R45 stated no one had ever discussed the survey results with her and she was not aware that there was report that she could review. During interview with the activity director, who			

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F 167	Continued From page 2 directed the Resident Council meetings, at 3:00 p.m. on 2/2/12, verified she was not aware of the survey results being addressed during the resident council meetings and stated she was not sure if or when they were addressed. The facility failed to make the survey results available in an appropriate location that was easily accessible by residents and failed to maintain the residents right to examine the results of the most recent survey and correction plan.	F 167		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS . The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		

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F 225	Continued From page 3 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to timely report potential allegations of abuse and neglect to the administrator and stage agency according to as directed in the facility abuse policy. This affected 4 of 4 residents (R4, R80, R69 and R122) involved in reportable incidents. Findings include: An incident report dated 12/2/11, revealed resident to resident altercations had occurred. At 2:00 p.m. on 12/1/11, 80 struck R4 and threatened R69 by stating he was going to "punch him out, smash his head in." The report indicated the state agency had been notified on 12/2/11 (time unknown), but the administrator had not been notified. An incident report at 1:40 p.m. on 1/23/12, revealed R122 had sustained a fall and his fall interventions had not been in place according to	F 225	**F225D** Nursing Staff were educated on VA policy and criteria for completing an incident report on 3-9-12. All Charge Nurses were trained on the VA policy and procedure to immediately report incidents to State agency and/or CEP on 2-27-12. The Administrator and DON's email addresses to the incident reporting system. The incident cover sheets were updated to include a time category for notification of the Administrator. All incident reports will be audited on a daily basis by the DON/designee to monitor reporting compliance. Audit results will be brought to the QA committee for review and further recommendations. Completion date 3-16-12	

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F 225	Continued From page 4 his plan of care. The facility notified the administrator and the state agency on 1/30/12, seven days after the incident occurred. Review of the facility Abuse Prevention Policy updated 1/12, directed the staff to immediately report any allegations of abuse and neglect to the administrator and the state agency. At 9:30 a.m. on 2/2/12, the director of nursing (DON) stated the facility policy to report immediately to the administrator and the state agency had been updated within the last three weeks. She stated since the time of the policy update, the facility had not had any type of reportable incidents. She reviewed the resident to resident altercation incident and verified the administrator had not been notified timely. She stated she was sure that he had been notified but was unsure of when. She then reviewed the incident involving R122. She stated the computers had not been working properly on 1/23/12, and she was not able to complete the investigation timely. She verified the administrator and the state agency had not been notified until seven days after the event. She verified the facility policy had not been followed. At 4:00 p.m. on 2/2/12, the DON provided a copy of an email at 4:30 p.m. on 12/2/11, from the state agency which had been sent to the administrator notifying him of the received incident report involving R4, R80 and R69.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		

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F 226	Continued From page 5 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to implement their policy for abuse and neglect timely. This affected 4 of 4 residents (R4, R80, R69 and R122) involved in reportable incidents. Findings include: An incident report dated 12/2/11, revealed resident to resident altercations. At 2:00 p.m. on 12/1/11, R80 struck R4 and threatened R69 by stating he was going to "punch him out, smash his head in." The report indicated the state agency had been notified on 12/2/11 (time unknown) but the administrator had not been notified. An incident report at 1:40 p.m. on 1/23/12, revealed R122 had sustained a fall and his fall interventions had not been in place according to his plan of care. The facility notified the administrator and the state agency on 1/30/12, seven days after the incident occurred. Review of the facility Abuse Prevention Policy updated 1/12, directed the staff to immediately report any allegations of abuse and neglect to the administrator and the state agency. Review of the previous Abuse Prevention Policy dated 3/11, revealed the facility had up to 24 hours to report the incidents to the administrator and the state agency.	F 226	**F226D** Nursing staff were immediately educated on VA policy and criteria for completing an incident report and to immediately report Incidents to the State agency and/or CEP on 1-27-12 and 2-27-12. The Administrator and DON's email addresses to the incident reporting system. The incident cover sheets were updated to include a time category for notification of the Administrator. The VA Policy was reviewed and revised as needed. All charge nurses were trained on the updated VA policy on 2-27-12. All incident reports will be audited on a daily basis by the DON/designee to monitor reporting compliance. Audit results will be brought to the QA Committee for further recommendations. Completion Date 3-16-12	

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F 226	Continued From page 6 At 9:30 a.m. on 2/2/12, the director of nursing (DON) stated the facility policy to report immediately to the administrator and the state agency had been updated within the last three weeks. She verified the previous policy had directed the staff to report to the state agency and the administrator within 24 hours. She stated since the time of the policy update, the facility had not had any type of reportable incidents. She reviewed the resident to resident altercation incident and verified the administrator had not been notified timely. She stated she was sure that he had been notified but was unsure of when. She then reviewed the incident involving R122. She stated the computers had not been working properly on 1/23/12 and she was not able to complete the investigation timely. She verified the administrator and the state agency had not been notified until seven days after the event. She verified the facility policy had not been followed. At 4:00 p.m. on 2/2/12, the DON provided a copy of an email at 4:30 p.m. dated 12/2/11, from the state agency which had been sent to the administrator notifying him of the received incident report involving R4, R80 and R69.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 253		

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F 253	Continued From page 7 review, the facility failed to provide maintenance and housekeeping services to maintain hallways, resident rooms, resident bathrooms, tub rooms and resident equipment in a safe and sanitary manner in 4 of the 5 units. This had the potential to affect 72 of 83 residents in the facility. Findings include: During the environmental tour at 2:00 p.m. on 2/2/12, with the administrator, director of nursing (DON), maintenance director (M-A) and housekeeping supervisor (HK-A) and throughout the survey the following was noted. The hallways on the Park Avenue, Pacific, Atlantic and Main unit were stained with black build up along the base boards and resident room door thresholds. The tile flooring had cracks and gaps that collected debris and were an unclean able surface. M-A verified that the blacken areas in the hallways were wax build up and that he had not tried to strip them. The administrator verified that the tile was in disrepair and unclean able. At approximately 2:25 p.m. on 2/2/12, it was observed, with the DON present, that five toothbrushes were lying directly on a shelf under the mirror in the bathroom in resident room #113. The shelf was dusty and had brown stains. The DON verified at that time that residents tooth brush should not be stored in such a manner. On the Pacific Unit resident rooms #159, #176, #177, #178, and #180 had cracks in the walls and under the windows. M-A indicated the cracks were due to the building shifting and that there was nothing he could do about it. M-A further	F 253	F253E • Will re-develop a cleaning schedule for the hallways of Park, Pacific, Atlantic, and Main Avenues. • Will re-develop a cleaning schedule for all resident rooms, resident bathrooms, and tub rooms. • Will replace cracked tiles. Will clean and annually strip/wax tile flooring as rooms and areas become available with resident vacancies. • Toothbrushes will be stored in the resident's bathroom cabinet or in the residents bedside table. DON will audit 5 resident rooms per week and results will be submitted to the QA committee for further recommendations. • Will fix/repair/paint cracks in the walls in all resident rooms. Will monitor as necessary.	

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F 253	Continued From page 8 indicated if he filled the crack and painted over them the cracks would reappear. Dirty and dusty bathroom exhaust vents where noted in resident rooms #104, #119, #126, # 128, #131, #133, #139, #141, #142, #145, #154, and #177. Dirty floors were noted in resident rooms and bathrooms: #102, #104, #106, #108, #112, #142, and #180. Chipped veneer on closet doors and chipped wall paint were noted in rooms #102, #105, #126, #139, #142, #154, and #159. The Nostalgic family room at the end of the main unit had stained carpeting and the heating vent was noted to have black scuff marks. The vents were rusty and had a dusty build up. M-A verified that the carpet was stained and the heating vent required cleaning. The tub rooms on the Atlantic and Pacific wing had cracked and missing tile on the floor. Both tub rooms had yellow stains under the tub. The Atlantic tub room and an area of missing plaster on the wall at the foot of the tub that was approximately two feet by one foot in size. On the Pacific unit, two of two mechanical lifts were noted to have a heavy buildup of food debris on the foot boards. In addition, one of the lifts had torn vinyl on both side bars that the residents hold on to during transfers. The DON verified at approximately 2:35 p.m. on 2/12/12, that the lifts should be cleaned weekly and that she was unaware of the torn vinyl.	F	• Will add dusting of exhaust vents in resident rooms to the cleaning schedules. • Will replace veneer on closet doors of resident rooms and will fix/repair/paint chipped walls where noted. • Will shampoo carpet in the nostalgic room. Will fix/repair/replace/paint vents. • Will replace tile flooring in resident tub rooms. Will replace missing plaster. • Mechanical Lifts- Housekeeping will clean lifts once per week, DAC will clean once per week, and Nursing will clean daily as needed. Maintenance will replace torn vinyl on handles and will inspect on a monthly basis. • Will add dusting/cleaning/removing debris of brick and artificial plants to cleaning schedule. Will be reviewed and audited by the Director of Env Services. • Will educate staff on the importance of cleaning up spills immediately. • Audit results will be brought to the QA Committee for further recommendations. Completion Date 3-16-12	

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F 253	Continued From page 9 During an interview at 3:00 p.m. on 2/12/12, M-A indicated if staff had maintenance concerns they would fill out a maintenance request form. M-A verified he did not have any current requesting regarding the flooring or chipped veneer and paint. M-A further indicated that it was an old building and something's would have to be replaced. The entrance in to the Park Avenue area had a sitting area that contained plastic flowers on the floor and plastic tree branches on the walls and ceiling. At 9:30 a.m. on 2/3/12, the area was observed with HK-A. The branches hanging from the ceiling were noted to be dusty and the base on the brick surrounding the plastic plants was noted to also be dusty and to have a heavy buildup of debris at the base of the bricks and flooring. HK-A verified the findings and indicated that staff clean that area when there was extra time. Review of the facility's Housekeeping Wing Assignment policy dated 11/1/11, indicated that when three housekeepers are on duty, individual daily room cleaning should include: a> Floors (sweep and mop) b> Dusting (TV, Tables, air vents Etc.) c> Toilet d> Garbage e> Under the bed f> Visual inspection of ceiling and walls and cleaning spots g> Window blinds The policy further indicated that if four housekeepers were on duty or if extra time was	F 253		

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F 253	Continued From page 10 available, that staff should dust the foliage, vacuum and greens (plastic plants) and clean air vents in the hallways and resident rooms. The policy also specified instructions for when there are only one or two housekeepers available. HK-A indicated at 9:35 a.m. on 2/2/12, the facility tried to have three housekeepers on during the day shift. R10's room was not kept in a clean and sanitary manner. At 4:30 p.m. on 1/30/12, R10's family member stated she frequently cleaned the floor R10's room because he would spit and she would frequently find sputum on the floor. At 7:10 a.m. on 2/1/12, R10 rested in bed. The floor was noted to have five areas which contained a dried green material. The areas ranged from the size of a dime to half dollar size. At 9:00 a.m. nursing assistant (NA)-A entered the room and delivered a breakfast tray to R10. She was not observed to remove the matter from the floor. At 9:30 a.m. licensed practical nurse (LPN)-D assisted R10 with his morning cares. When she had left the room, the matter on the floor was untouched. At 12:45 p.m. NA-A stated R10 had a history of spitting on the floor and the staff encouraged him to use tissues. She stated if she noticed any concerns with the floor, she would clean them up. At 1:30 p.m. R10's floor continued to have dried sputum on the floor.	F 253		

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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 253	Continued From page 11 At 8:30 a.m. on 2/2/12, R10's floor was clean. At 12:00 p.m. on 2/2/12, housekeeper-B stated R10 frequently has sputum on his floor. She stated R10's room was cleaned daily. She further commented if any concerns are identified in-between cleaning, the staff member who identified the concerns were to clean the area or alert the housekeeping staff. At 12:35 p.m. on 2/2/12, registered nurse (RN)-A stated if a concern was identified on the floor, the staff member noticing the concern should assist in cleaning it or alerting the housekeeping staff. At 1:45 p.m. on 2/2/12, the DON verified the floors were to be cleaned as soon as a concern was identified.	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to provide services in accordance with the written plan of care (POC) for 1 of 3 residents (R10) in the sample who required interventions to reduce the risk for falls. Findings include:	F 282		

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F 282	Continued From page 12 R10's diagnoses included anxiety, depression, muscle weakness and he had a history of falls. The plan of care printed on 2/2/12, directed the staff to ensure he had a pressure pad alarm (a pressure sensitive pad that is connected to call light system that alerts caregiver(s) with audio sound when patient gets out of bed) system connected to the call light system while in bed. However, on 2/1/12, from 7:10 a.m. through 9:00 a.m. R10 was observed in his bed without the bed alarm connected to the call system. In addition, at 8:15 a.m. R10 sat on the edge of the bed by himself as he reached for his wheelchair. The staff was not alerted to R10's movement. At 9:00 a.m. on 2/2/12, nursing assistant (NA)-A connected the bed alarm to the call system. She stated the alarm would not sound if it was not connected. At 12:35 p.m. on 2/2/12, registered nurse (RN)-A verified the alarm was to be connected and R10's plan of care had not been followed.	F 282	F282D All nursing staff will be trained on procedure to change Arial alarm box from a bed pressure pad to a wheelchair pressure pad. Residents with Arial alarm bed pad and wheel chair pad will be audited randomly that alarms are all connected to the correct alarm pad. Audits will be conducted 2x/wk for 4 weeks, then 1x /wk for 4 weeks, then monthly. Audits will be conducted by the Unit managers and then submitted to the QA committee for further recommendations. Completion Date 3-16-12	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

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F 314	Continued From page 13 by: Based on document review, interview, and observation, the facility failed to comprehensively assess and implement interventions to prevent the development of a new pressure ulcer for 1 of 3 residents (R17) in the sample of residents who had a history of pressure ulcers. Findings include: R17 had the diagnoses which included obstructive hydrocephalus; organic brain syndrome, paralysis agitans (Parkinson's disease); history of pressure ulcers of the toe and heel, convulsions, and mild mental retardation. R17's nose sore was not identified or assessed by the facility staff until the surveyor brought it to the attention of the director of nurses (DON) at 9:54 a.m. on 2/3/12. The DON verified the sore was a Stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) and immediately reported it to the wound nurse. During an interview at 5:13 p.m. on 1/30/12, R17 told the surveyor that his nose was sore. R17 was thin with a prominent nose that had enlarged prominences near the bridge area. R17 was wearing glasses that had foam padding along the entire length of the bows, on the left side; the foam had come loose and was just hanging out to the side. At 9:02 a.m. on 2/1/12, R17 was sitting in the dining room with two slices of toast sitting in front of him and his glasses were off and sitting on the table. Licensed practical nurse (LPN)- E encouraged R17 to eat his toast and placed his	F 314	F314D R17 had a skin assessment of the reddened area on his nose on 2-3-12 and interventions were initiated to promote healing and prevent further breakdown. All Nursing staff was re-trained on observing potential areas prone to skin breakdown on 3-9-12. Nursing staff will recognize potential issues and report to our certified Wound nurse who will then assess and complete a Root Cause Analysis of the skin issue and put appropriate interventions into place. Random audits will be conducted by the DON/designee 2x/wk for 4 weeks, then weekly for 4 weeks. Then monthly thereafter to ensure skin issues are being identified and reported from our weekly skin checks. Audit results will be brought to the QA Committee for further recommendations. Completion Date 3-16-12	

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F 314	Continued From page 14 glasses back on. R17 returned to his room with his toast and remained there until 11:28 a.m. at which time the surveyor again noted that his nose looked very sore. R17 was questioned how his nose area was and to which he replied, "It's kinda sore". The red lump was becoming more red and enlarged. The Annual Minimum Data Set (MDS) on 12/14/11, identified R17 had impairment of memory recall and temporal orientation (to year, month, and day), delusions, and behavioral symptoms of physical abuse directed towards others, rejection of personal cares, verbal abuse of others, and socially inappropriate behaviors. R17 required extensive physical assistance of staff in bed mobility, transfers, dressing, and toilet use, and was unable to walk. R17 was frequently incontinent of urine and occasionally incontinent of bowel and was identified as high risk for pressure ulcer development. Review of the Tissue Tolerance Results report reviewed in the nursing progress notes on 12/8/11, revealed that R17 was at risk for skin breakdown related to poor dietary intake, mobility, friction and shear forces, and incontinence. The assessment indicated, "Staff will continue to assist patient with personal cares and observe for breakdown in tissue." The Care Area Assessment (CAA), Analysis of Findings regarding Pressure Ulcers on 12/21/11, identified that R17 was at risk for skin breakdown related to co-morbidities, chronic edema, decreased mobility, confusion, and incontinence. Review of the West Wind Village Care Guide	F 314		

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F 314	Continued From page 15 dated 2/1/12, for R17, under the Vision section identified the intervention of "Foam on bows of glasses to prevent breakdown." The care guide did not identify the sore on the left side on the bridge of the nose, nor were interventions developed for treatment and protection of the area to prevent further breakdown. Review of the Care Planning Report effective date 2/2/12, identified R17 was at risk for skin breakdown related to decreased mobility, increased confusion, lethargy, and incontinence of bowel and bladder. The care plan indicated R17 had a history of Stage 1 pressure ulcer to the right heel and stage 2 pressure ulcer (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) to the right great toe. Interventions included: "Ensure foam pieces stay on glasses to relieve pressure bid which started 11/6/09. Weekly skin check with bath which was approved 3/25/10. Monitor for skin redness which was approved 5/11/11." Vision was identified as a problem and had the intervention of "Foam on bows of glasses to prevent breakdown which was approved 3/24/10." Nursing assistant (NA)-D was interviewed at 11:50 a.m. on 2/2/12, and reported the nurse's aides (NA's) are to notify the team leader or the floor nurse if they see a skin issue. NA-D stated the skin assessments are completed weekly with the resident's bath and they are to report any changes in skin that are noted. At 11:31 a.m. on 2/2/12, Clinical Manager (CM)-A verified nothing had been charted on R17's last	F 314		

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F 314	Continued From page 16 weekly skin assessment. CM-A commented, "I will ask my staff nurse what she knows and then [will] get back to you." After CM-A spoke with the staff nurse she concluded R17 had behaviors related to his bi-pap (a mask worn at night for sleep apnea) which she believed may have caused the nose sore. She revealed that R17 moves it around on his face or throws it on the floor. CM-A acknowledged R17's current skin assessments did not reflect the sore on his nose, how it developed, or what interventions should be implemented for treatment and prevention of further deterioration of the skin. At 9:54 a.m. on 2/2/12, the DON assessed R17's nose and verified the sore was a Stage 1 pressure ulcer caused by pressure from R17's glasses rubbing on his nose. The DON verified R17's new skin problem should have been noted on the most current skin assessment and acknowledged that it had been overlooked by all staff. The DON stated nursing interventions should have been developed for treatment and prevention of further skin breakdown. The Wound Nurse assessed R17 at 10:00 a.m. on 2/3/12, verified the cause of the Stage 1 pressure ulcer of the nose was related to the prong on R17's glasses being pushed in. The wound nurse stated she would immediately notify the doctor and implement daily monitoring of the skin area and the prongs on R17's glasses.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 17 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure preventative measures to reduce/minimize the risk of falls had been correctly implemented for 1 of 3 residents (R10) identified at risk for falls. In addition they failed to ensure the side rails were fitting the bed appropriately for 2 of 2 residents (R96 and R72) who utilized rails. Findings include: R10's diagnoses included anxiety, depression, general muscle weakness, and he had a history of falls. R10's preventative fall interventions were not applied appropriately according to the plan of care. At 7:10 a.m. on 2/1/12, R10 rested in bed with his wheelchair next to him. The bed was equipped with a sensor pad (a pressure sensitive pad that is connected to call light system that alerts caregiver(s) with audio sound when patient gets out of bed); however, the sensor pad was not connected to the alarm box which prevent it from notifying the staff of any attempts to self-transfer. At 8:15 a.m. on 2/2/12, R10 sat up on the edge of his bed and reached for his wheelchair. He was unable to transfer himself a returned to a laying position in the bed. The bed alarm was not	F 323	**F323D** • All nursing staff will be trained on procedure to change Arial alarm box from a bed pressure pad to a wheelchair pressure pad. Residents with Arial alarm bed pad and wheel chair pad will be audited randomly that alarms are all connected to the correct alarm pad. Audits will be conducted 2x/wk for 4 weeks, then 1x /wk for 4 weeks, then monthly. Audits will be conducted by the Unit managers and then submitted to the QA committee for further recommendations. • Will replace side rails to meet current FDA regulations. Will educate RNs on FDA regulations. • Will update side rail assessment policy. • Will measure each side rail that is put on to ensure proper FDA requirements are being followed. • All bedrails will be audited by Env. Services on a Quarterly basis to ensure are FDA approved • Audit results will be brought to QA Committee for review and further recommendations. Completion Date 3-16-12	

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F 323	Continued From page 18 observed to sound during that time. At 9:00 a.m. at 2/2/12, nursing assistant (NA)-A entered the room and offered R10 breakfast. R10 refused the meal and remained in bed. NA-A then disconnected the alarm system from the wheelchair and connected the bed alarm to the bed sensor pad. She stated the bed sensor was to be connected to ensure it alerted the staff of R10's potential to transfer himself. The record also contained a Fall Care Area Assessment (CAA) dated 8/10/11, which identified his high risk of falls and directed the staff to utilize a personal alarm on his bed. The quarterly minimum data set (MDS) dated 1/5/12, identified R10 with cognitive impairments, requiring extensive assistance of one staff for transfer and ambulation. The MDS also identified R10 as having a history of falls. The Fall Risk Assessment dated 1/3/12, identified R10 as a high risk for falls. The plan of care printed on 2/2/12, directed the staff to utilize a personal alarm on his bed which was to be connected into the call light system to alert staff of possible attempts to transfer himself. Review of the progress notes dated 9/1/11-2/2/12, indicated R10 had sustained seven falls without injury. At 12:25 p.m. on 2/2/12, licensed practical nurse (LPN)-D stated R10 had been sitting in his wheelchair when she arrived at the facility at 6:30 a.m. She stated she did not know when he transferred himself to the bed, but stated the bed alarm should have been connected at the time of his transfer.	F 323		

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F 323	Continued From page 19 At 12:35 p.m. on 2/2/12, registered nurse (RN)-A stated the alarm system was to be connected to the alarm box to notify the staff of any potential attempts to self-transfer. She verified the plan of care had not been followed. At 1:45 p.m. on 2/2/12, the director of nursing verified the bed sensor was to be connected to the alarm box. R96's diagnoses include dementia with behavioral disturbance, anxiety and muscle weakness. R96 had a recent history of falling out of bed, had bed side rails that were not assessed to determine if they meet the Federal Drug Administrations (FDA) recommendations for safety. A quarterly MDS dated 11/29/11, indicated the resident had a BIMS (Brief Instrument of Mental Status) score of 5 which identified R96 as having a cognitive impairment. The MDS further identified R96 as requiring extensive staff assistance with bed mobility and transfers. The nursing notes from 12/24/11 to 1/29/12, were reviewed. A nursing note dated 12/19/12, indicated R96 had fallen when attempting transfer herself from the bed to the wheelchair. A nursing note dated 12/24/11, indicated that R96 was observed sitting at the side of the bed with her personal alarm was sounding. A nurse assistant was able to reach the resident just before she slide to the floor. A progress note date 1/29/12, by the register	F 323		

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F 323	Continued From page 20 nurse manager of the secured unit (RN)-B indicated, "The resident has been assessed to safely use a 1/2 side rail. Resident utilizes a 1/2 rail for bed mobility, repositioning, to support self with sitting up and entering/exiting bed safely. Resident's cognitive status she is confused with a diagnosis of dementia with behaviors, and restlessness she self-transfers and utilized the side rail to safely stand up alone and weight and build indicate no safety risk with use of 1/2 rail. Side rails are secure, rigid and close to the mattress and meet FDA guidelines. The side rail does not impede resident's movements or obstruct the resident's view. Resident wishes to continue utilizing 1/2 side rails." R96's bed was observed at 4:45 p.m. and 7:45 p.m. on 1/30/12, R96 was observed in bed with both side rails in the up position. At 7:30 a.m. on 2/1/12, R96's side rails were measured when the resident was not in bed. FDA guidelines dated 3/2006, recommend that side rails should fit firmly to the mattress and spacing between the bars be limited to prevent entrapment. The FDA recommends zone 2, which was the area under the rail, between the rail supports be less than 4 and 3/4 inches. The area between the rail supports on R96's bed was 7 and 3/4 inches. The FDA recommends that zone 4 which was the area under the rail, at the ends of the rail and the mattress be less the 2 and 3/8 inches. R96 mattress measured 3 and 1/2 inches from the ends of the rail to mattress. In addition, R96 mattress did not fit firmly to the to the bed frame	F 323		

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F 323	Continued From page 21 and could slide another two inches away from the side rail. During an interview at 9:17 a.m. on 2/1/12, RN-B indicated R96 had fallen when attempting to exit her bed during the p.m. of 1/31/12, and a curved mattress would be placed on the resident's bed. Record review indicated the resident had not sustained an injury. During an interview at 11:50 a.m. on 2/1/12, RN-B was asked about the side rail assessment she had completed on 1/29/12. RN-B verified she had not actually measured R96 rails or assessed the bed to determine if the mattress fit tightly to the rails to determine if they imposed an entrapment risk. RN-B indicated that the maintenance director (M-A) had told her all the side rails in the facility were FDA approved and that the assessment she completed on the computer charting was a template that she just filled in the blanks. RN-B verified she was unaware of the FDA guide lines published 3/2006. During an interview at 12:10 p.m. on 2/12/12, M-A verified he had not measured or assessed R96 side rails or mattress. M-A indicated the bed was obtained from another sister facility so he just assumed they were safe. R72 bed side rails on her bed were not assessed to determine if they meet the Federal Drug Administrations (FDA) recommendations for safety. R72's diagnoses include dementia with behavioral disturbance, delusions and psychosis. A quarterly MDS dated 12/30/11, indicated the	F 323		

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F 323	Continued From page 22 resident had a BIMS score of 3 which identified R72 as having a cognitive impairment. The MDS further identified R72 as independent with bed mobility and transfers. On the p.m. of 1/30/12, and periods throughout the day on 1/31/12, R72 was observed in bed with two quarter rails in the up position. A progress note dated 1/30/12, by RN-B indicated R72 had been assessed to safely use a ½ side rails. "Resident utilizes a ½ rail for bed mobility, repositioning, to support self with sitting up and entering/exiting bed safely. Resident's cognitive status she is confused with a diagnosis of dementia with behaviors, she self-transfers and utilized the side rail to safely stand up alone and weight and build indicate no safety risk with use of 1/2 rail. Side rails are secure, rigid and close to the mattress and meet FDA guidelines. The side rail does not impede resident's movements or obstruct the residents view." At 7:45 a.m. on 2/1/12, R72's side rails were measured when the resident was not in bed. The FDA recommends zone 2, which is the area under the rail, between the rail supports be less than 4 and ¾ inches. The area between the rail supports on R72's bed was 7 and ¾ inches. The FDA recommends that zone 4 which was the area under the rail, at the ends of the rail and the mattress be less the 2 and 3/8 inches. R72 mattress measured 3 and 1/2 inches from the ends of the rail to mattress. During an interview at 11:50 a.m. on 2/1/12,	F 323		

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F 323	Continued From page 23 RN-B verified she had not measured R72 side rails to determine if they met the FDA recommendation and that she just completed the template because M-A told her all the side rails in the facility met the FDA standards.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review, and staff interview, the facility failed to identify drug irregularities for	F 329	F329D Nurse Managers were educated on Procedures for unnecessary drugs on 3-9-12; Nurse Managers will obtain clinical rational as requested by the Pharmacist. Will implement Consulting Pharmacist Medication Review Form created by Consulting Pharmacy. Nursing staff will audit all resident charts for any unnecessary drugs to ensure there is adequate indications for their use. Random audits of 10 resident records per month will be completed by the DON/designee. Audit results will be brought to QA Committee for review and further recommendations. Completion Date 3-16-12	

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F 329	Continued From page 24 dosing requirements and adequate indications for use or continued need of antihistamine medication in the presence of adverse reactions as recommended by the consultant pharmacist for 1 of 10 (R67) residents in the sample reviewed for the use of unnecessary medications. Findings include: R67 continued to receive Tylenol PM (used to treat pain and help you fall to sleep) on an as needed basis (PRN) without supporting diagnosis for need or rationale for continued use despite potential adverse side effects which included syncope episodes (fainting). In addition, the medication order did not include the drug dosage to be administered. R67 had diagnoses which included Parkinson's disease, orthostatic hypotension (blood pressure dropping upon standing), hypotension (low blood pressure), syncope with collapse (fainting spells), sleep apnea, and anemia with recent blood transfusions. The Annual Minimum Data Set (MDS) on 12/22/11, identified that R67 was alert and oriented, had indicators of depression including feeling tired or having little energy nearly every day and trouble staying asleep or sleeping too much. R67 required extensive staff assistance with bed mobility, transfers, dressing, and toilet use. Review of the behavior summary on 12/22/11, revealed, "Patient appears to sleep well. Patient does not receive pharmalogical or nonpharmacological interventions for sleep." The	F 329		

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F 329	Continued From page 25 summary did not identify that R67 used the Tylenol PM for sleep. The Care Area Assessment (CAA) on 12/28/11, identified adverse medication consequences of increased risk for falls, postural hypotension, orthostatic hypotension, lethargy, mental depression, and disturbances of balance. Review of Progress Notes from 11/11 through 2/12, indicated R67 had orthostatic changes (drops in blood pressure) with "occ (occasional) spells of low BP (blood pressure), unresponsive spells on toilet." Review of the nurses notes identified the spells would last from 10-45 seconds with R67's eyes closed and arms going limp. The Care Guide dated 2/2/12, identified safety concerns of "Severe postural hypotension, especially with bowel movements, MUST STAY IN ROOM WHILE RESIDENT IS IN THE BATHROOM. DO NOT LEAVE ALONE." On 11/18/11, the consultant pharmacist made recommendations to discontinue Tylenol PM due to minimal effectiveness and R67 experiencing the potential side effects of "weird dreams, dry mouth, and also woke up not feeling well." R67 also experienced stiffness and shaking. Staff had reported the effectiveness of the medication as "hit and miss." Review of the physician's progress notes, physician's orders, and the Medication Administration Records (MAR) revealed R67 continued to take the medication on a PRN basis without physician review for adequate indications for use and continued need despite potential adverse side effects.	F 329		

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F 329	Continued From page 26 Review of the current Physician's Orders (no date indicated on computer copy) identified that Tylenol PM Extra strength, 2 tabs was ordered to be given at night on a PRN basis. The order read, "continuous prn repeating." The order did not specify a diagnosis for use nor did it clarify the specific amount of medication per tablet. Each tablet contained an amount of Tylenol and an amount of Benadryl (diphenhydramine), but the order did not indicate exact amounts to be given besides, "2 tabs". Review of the Medical Records Information form revealed R67's physician examined R67 on 12/1/11, and 1/25/12, and did not evaluate the continued need for Tylenol PM as recommended by the consultant pharmacist on 11/18/11. At 9:37 a.m. on 2/3/12, Clinical Manager (CM)-A acknowledged the medication should have been reviewed as recommended by the consultant pharmacist but added, "R67 does what she wants; [the doctor] never discontinued it." CM-A verified the physician should have included a risk versus benefit statement if he wanted her to continue on the medication. Interview with the director of nurses at 10:00 a.m. on 2/3/12, verified that it was the expectation of the nursing staff to review the pharmacy recommendations and to update the physician if irregularities are identified.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	Continued From page 27 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation; interview and document review, the facility failed to store, prepare, distribute and serve food under sanitary conditions which had the potential to affect 83 of 83 residents in the sample. Findings include: During the initial kitchen environment inspection at 2:00 p.m. on 1/30/12, the following findings were noted. The side by side refrigerator and freezer in the kitchen food preparation area was noted to have excess dust and debris on top of them that was noted to fall off in balls of dust when a hand was raked across the top. The large mixer bowl was noted to have a large amount of dried food particles on the agitator arm and arm assembly. The food debris was noted to be caked on around the bolt that secured the agitator arm to the motor unit. The Dietary manager stated the mixer was used daily and had not been used yet today. All air flow vents (heater/exhaust) in the kitchen	F 371	F371F Will clean tops of refrigerator 2x/month. A deep cleaning of the mixer will be conducted after each use. Will dust vents 2x/month. Will thoroughly clean can opener after each use. Will buy new potato peeler. Will educate staff on new cleaning schedules Will educate staff on proper hand-washing, frequency of changing of gloves, and food serving techniques. Will conduct a random audit 2x/wk for 4 weeks, then 1x/wk for 4 weeks, then monthly. Audit results will be brought to QA Committee for review and further recommendations. Completion Date 3-16-12	

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F 371	Continued From page 28 where noted to be heavily covered with dust and the dust was noted to be hanging from them directly over food preparation and food service areas. The commercial grade can opener, on the food preparation counter, was noted to be heavily soiled around and behind the cutting blade and the blade assembly where it mounted to the unit motor. The facility had a commercial grade electric potato peeler that was noted to have excess mineral deposit on the peeling plate (internal plate that came in direct contact with food). The opening at the top of the peeler had mineral buildup that was noted to be flaking off and falling into the peeler unit. During the inspection the dietary manager was present and verified the findings. The dietary manager stated the maintenance department was responsible for cleaning high areas and stated she had a schedule for cleaning the mixer and can opener. The director stated she was not sure what to do about the potato peeler as it was unable to be cleaned. At 9:30 a.m. on 2/1/12, the kitchen environment was inspected with the maintenance director and his assistant. During the inspection the vents and high areas (refrigerator/freezer tops, light fixtures and ceiling vents) in the kitchen continued to be heavily soiled. The maintenance director verified the findings and stated maintenance was responsible for cleaning the vents and light fixtures but the kitchen personnel where responsible to clean the tops of food storage	F 371		

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F 371	Continued From page 29 units. The director verified the findings on the potato peeler and stated the only way for it to be cleaned was to purchase another internal plate for the unit. The maintenance director stated there was a cleaning schedule for the vents and light fixtures to be cleaned monthly but verified if they had been cleaned the cleaning schedule was ineffective and the cleaning needed to be done more frequently. At 11:45 a.m. on 2/2/12, the noon meal was observed for preparation and service. During the observation it was noted that all of the concerns identified on 1/30/12 during the initial inspection continued to be present. The facility failed to have a system in place to ensure food was stored, prepared and distributed under sanitary conditions. The facility did not ensure food was served under sanitary conditions for the meal service on 1/30/12. At 5:15 p.m. on 1/30/12, the evening meal was served to the 38 residents and one family member in the main dining room. The steam table was set up with two meal choices. The first choice was a polish sausage and boiled cabbage. The second choice was cream of asparagus soup and a grilled cheese sandwich. Cook-A wore gloves as she served the meal. At 5:19 p.m. cook-A picked up a glass, opened the refrigerator, removed a gallon of milk, poured it into the glass, replaced the milk and shut the door. She then was observed to go back to the steam table and dished up a bowl of soup and reached into the steam table with her soiled	F 371		

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F 371	Continued From page 30 gloved hand, picked up a sandwich, placed it on the plate and set it up on the counter for the nursing staff to deliver it a resident. At 5:23 p.m. cook-A rubbed her nose with the back of her soiled gloved hand. She was not observed to change her gloves or wash her hands as she continued to dish the meals for the residents. At 5:25 p.m. cook-A walked around the steam table area, removed the coffee pot filter, carried it behind the counter, placed a new filter and grounds, replaced the filter into the coffee machine and pushed the button to start it. She then returned to the steam table, dished another meal for a resident again reaching directly into the container of grilled cheese sandwiches and touched the sandwich with her soiled gloved hand as she placed it onto the plate. At 5:27 p.m. licensed practical nurse (LPN)-C walked into the kitchenette area, opened the refrigerator, removed a gallon of milk and poured a glass of milk. She then replaced the milk in the refrigerator. At 5:28 p.m. cook-A opened the fridge with her soiled gloved hand and removed a plate from the refrigerator and handed it to a nursing staff member to deliver to a resident. She then continued to serve meals from the steam table, each time reaching directly into the container of grilled cheese sandwiches with her soiled gloved hand. At 5:30 p.m. nursing assistant (NA)-C asked cook-A for a specialized cup. Cook-A wore the same soiled gloves as she opened the door to the kitchen and momentarily returned with a cup. She was not observed to wash her hands or change	F 371		

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F 371	Continued From page 31 her gloves after touching the kitchen door. Cook-A continued to dish up meals for the residents, directly touching the sandwiches. At 5:37 p.m. cook-A opened the door to the kitchen with her soiled gloved hands and returned with another cup. She again returned to the steam table and dished up meals for the residents without changing her soiled gloves or washing her hands. At 5:40 p.m. cook-A removed the items from the steam table, removed her gloves and washed her hands in a sink located behind the steam table. That was the first time the cook had removed her gloves during the entire meal service.	F 371		
F 465 SS=F	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 maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Findings include: During the initial kitchen environment inspection at 2:00 p.m. on 1/30/12, the following findings were noted.	F 465	**F465F** Will dust vents 2x/month Will dust light fixtures 2x/month Will clean tops of refrigerator/freezer 2x/month. Equipment- Dietary staff will add to their monthly cleaning schedule- Will look at replacing some pieces of equipment. Freezers- on top- Maintenance will add to their monthly cleaning schedule. Light Fixtures- Maintenance will add to their monthly cleaning schedule Vents- Maintenance will add to their monthly cleaning schedule	

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F 465	Continued From page 32 All air flow vents (heater/exhaust) in the kitchen where noted to be heavily covered with dust and the dust was noted to be hanging from them. The vent was noted to be located over food preparation areas and also areas outside of the food preparation area. Light fixture covers were noted to have excess dust hanging from the side which could be easily visualized when walking into the kitchen area. During the inspection the dietary manager was present and verified the findings. The dietary manager stated the maintenance department was responsible for cleaning high areas. At 9:30 a.m. on 2/1/12, the kitchen environment was inspected with the maintenance director and his assistant. During the inspection the vents and high areas (refrigerator/freezer tops, light fixtures and ceiling vents) in the kitchen continued to be heavily soiled. The maintenance director verified the findings and stated maintenance was responsible for cleaning the vents and light fixtures but the kitchen personnel where responsible to clean the tops of food storage units. The maintenance director stated there was a cleaning schedule for the vents and light fixtures to be cleaned monthly but verified if they had been cleaned the cleaning schedule was ineffective and the cleaning needed to be done more frequently. The facility failed to have ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS	F 507		

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F 507	Continued From page 33 The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to obtain lab results for resident's medical records in a timely fashion for 2 of 10 residents (R34 and R17) in the sample whose medication regimens were reviewed. Findings include: R34 had the diagnoses that included dementia, coronary artery disease, hypertension, depression, anxiety, and a history of coronary artery bypass graft. R34 had lab work ordered by the physician on 10/17/11, and the results had not been obtained for review and management by the clinical staff. During the survey from 1/30/12, through 2/3/12, facility staff called to request the labs twice but was still unable to obtain the results. The Quarterly Minimum Data Set (MDS) on 11/15/11, identified R34 had impaired memory recall and required limited staff assistance for bed mobility, dressing, and toileting and extensive staff assistance for transfers. Review of the Physician Orders on 10/17/11, revealed that a complete blood count, and basic metabolic profile were ordered by the physician. R34's medication profile included use of Bystolic (for blood pressure), Zocor (for high cholesterol),	F 507	**F507D** Nursing staff were educated on the updated Lab Policy on 3-9-12. Obtaining lab work policy is updated to include: A copy of the current lab list will be made on Mondays and Wednesday and given to the nurse managers. The nurse manager will check lab list and ensure all lab reports have been received from the lab. If the report has not been received within 24 hours of the draw the labs will be contacted for the results. Random audits of lab reports will be completed by DON/designee 2x per week for 2 weeks, then 1x per week for 2 weeks, then monthly thereafter. Audit results will be brought to QA Committee for review and further recommendations. Completion Date 3-16-12	

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F 507	Continued From page 34 and Spironolactone (a diuretic). On 10/22/11, the consultant pharmacist reviewed R34's medication regimen and dictated, "Labs ordered + 10/17/11, dictation pending." At 1:00 p.m. on 2/2/12, the surveyor requested the ordered lab results as part of the comprehensive medication review. The review ensured the ordered labs were completed as ordered, reviewed, if any irregular results were present, and that they were reviewed by the physician. Clinical Manager (CM)-A was unable to find the results of the lab work in the resident's clinical record and called the lab to request that a copy be sent to the facility. On 2/3/12, the surveyor requested to see the results and CM-A stated that they still had not received the results. Record review revealed the attending physician evaluated R34 again on 1/17/12, and made no notation of the lab results that were ordered over three months ago. CM-A was interviewed at 1:15 p.m. on 2/12/12, and revealed there was an ongoing problem with the return of lab results to the facility and be placed in the resident's clinical records. CM-A stated she felt the problem was related to "technology"; problems with the fax machines along with results coming back late in the day and possibly being overlooked by the staff. R17 had the diagnoses that included obstructive hydrocephalus, organic brain syndrome, paralysis agitans (Parkinsons's disease), anemia, convulsions, and mild mental retardation. R17 had Dilantin (an anti-seizure medication that must be closely monitored due to the risk for	F 507		

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F 507	Continued From page 35 toxicity) levels drawn yearly in November. The Dilantin lab result could not be found in the resident's clinical record and were not made available for review until the surveyor made a request to the facility staff to call the lab and obtain the results. The Annual MDS on 12/14/11, identified that R17 had impairment of memory recall and temporal orientation (to year, month, and day), delusions, and behavioral symptoms of physical abuse directed towards others, rejection of personal cares, verbal abuse of others, and socially inappropriate behaviors. R17 required extensive physical assistance of staff in bed mobility, transfers, dressing, and toilet use, and was unable to walk. On 1/20/12, the consultant pharmacist reviewed R17's medication regimen and made the following request, "Nrsg {nursing}: taking Dilantin 250 mg {milligrams}at HS {night}, PO's {physician's orders} indicate order for annual Dilantin level in chart, please consider checking a Dilantin level if this has not already been done or place copy of the 11/11, results in chart if already done." CM-A was interviewed at 9:12 a.m. on 2/12/12, and stated she recalled that R17's lab work had been drawn as ordered but was unable to locate the results in the clinical record. CM-A called the lab and was able to obtain a result via the fax machine. Review of the Dilantin level revealed it was within normal limits. CM-A revealed they were having "serious issues with the two labs not returning resident's lab results." CM-A stated she was new to the unit and was not aware of the	F 507		

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F 507	Continued From page 36 issues that had taken place before she had worked there but had recently changed their process for management of labs. CM-A was hopeful that the new process would eliminate the problem of not maintaining resident labs for clinical monitoring. The director of nurses (DON) was interviewed at 10:30 a.m. on 2/3/12, and verified the lack of ordered labs available in the resident's clinical record in a timely fashion was a problem that the facility would assess, determine the causative factor, and implement the necessary measures to correct. The DON called the lab again on 2/3/12, to obtain the ordered labs for R34 and was still unable to retain the results before the end of the survey.	F 507		

F 52620 20

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

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245262	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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WEST WIND VILLAGE	1001 SCOTTS AVENUE MORRIS, MN 56267

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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: PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 E-mail: pat.sheehan@state.mn.us	K 000	RECEIVED MAR - 2 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok 3-5-12	

DC: 03.15.12

EXIT: 02.03.12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3-1-12

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 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 throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler	K 000		

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K 000	Continued From page 2 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. The facility has a capacity of 88 beds and had a census of 83 at the time of the survey. 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 requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K56 Will have Sprinkler Company come in to check system. Will tighten leaks through-out the anti-freeze loop. Completion Date 3-5-12	

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

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow damage to the sprinkler piping that would cause failures in the system and affect 24 of 83 residents, visitors and staff of the facility. Findings Include: On facility tour between 10:30 PM and 12:30 PM on 01/31/12, observations reveled that there were three sprinkler heads the were located in the chapel on the anti-freeze loop system that were leaking fluid. The results of this deficient practice can cause system malfunctions and or allow water to enter the system and possible freeze during freezing weather conditions. This deficient practice was verified by the Director of Environmental Services (BL)..	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8869

February 22, 2012

Mr. Michael Syltie, Administrator Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5262023

Dear Mr. Syltie:

The above facility was surveyed on January 30, 2012 through February 3, 2012 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, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

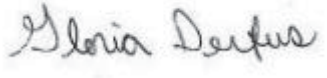
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1645 Energy Park Drive, St. Paul, Minnesota 55108. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

Please feel free to call me with any questions.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

cc: Original - Facility
Licensing and Certification File

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 _____	02/03/2012

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/30, 1/31, 2/1, 2/2, and 2/3/2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000		

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2 000	Continued From page 1 Licensing and Certification Program; 1505 Pebble Lake Rd, Suite 300, Fergus Falls, MN 56537.	2 000		
2 225	MN Rule 4658.0060 I. Responsibilities of Administrator The administrator is responsible for the: I. the development and maintenance of channels of communications with employees, including: (1) distribution of written personnel policies to employees; (2) regularly scheduled meetings of supervisory personnel; (3) an employee suggestion system; and (4) employee evaluation. This MN Requirement is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure all staff were informed of the Quality Assurance and Assessment (QAA) committee activities to enhance effectiveness of the committee. This practice had the potential to affect all 83 residents residing in the facility. Findings include: At 1:00 p.m. on 2/2/12, nursing assistant (NA)-A, a two year employee, stated she was not aware who was on the QAA committee nor was she aware of the function of the QAA committee. At 2:15 p.m. on 2/2/12, NA-B , a three year employee, stated she was not aware of the QAA committee members or functions. At 2:18 p.m. on 2/2/12, licensed practical nurse	2 225		

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2 225	Continued From page 2 (LPN)-B, a three year employee, stated she was not aware of the QAA committee or functions. At 2:33 p.m. on 2/2/12, laundry staff-C, a six month employee, stated she was not aware of the QAA committee or its functions. At 2:30 p.m. on 2/2/12, the licensed social worker (LSW) stated that she attended the QAA committee meetings on a quarterly basis and worked on projects as directed by the committee. She stated the direct care staff would not be aware of the QAA committee activity because the facility did not have a system to inform them of the committee activity. At 2:35 p.m. on 2/2/12, the administrator stated he was in charge of the QAA committee. He stated the committee met monthly and worked on improvement projects. When queried on how the direct care staff would be informed of the QAA activity, he stated they would not know because the committee did not have a system to communicate their activity to employees who were not on the committee. Review of the QAA committee membership list undated, did not include the direct care staff as being in attendance. The attendance roster only included department managers. SUGGESTED METHOD OF CORRECTION: The administrator could review an revise the policies and procedures related to quality assurance and develop a system in which the direct care staff could be made aware of the QAA committee activity. The administrator or designed could audit the staff to ensure compliance by monitoring ongoing communication.	2 225		

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2 225	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 225		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the written plan of care (POC) for 1 of 3 residents (R10) in the sample who required interventions to reduce the risk for falls. Findings include: R10's diagnoses included anxiety, depression, muscle weakness and he had a history of falls. The plan of care printed on 2/2/12, directed the staff to ensure he had a pressure pad alarm (a pressure sensitive pad that is connected to call light system that alerts caregiver(s) with audio sound when patient gets out of bed) system connected to the call light system while in bed. However, on 2/1/12 from 7:10 a.m. through 9:00 a.m. R10 was observed in his bed without the bed alarm connected to the call system. In addition, at 8:15 a.m. R10 sat on the edge of the bed by himself as he reached for his wheelchair. The staff was not alerted to R10's movement.	2 565		

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2 565	Continued From page 4 At 9:00 a.m. on 2/2/12, nursing assistant (NA)-A connected the bed alarm to the call system. She stated the alarm would not sound if it was not connected. At 12:35 p.m. on 2/2/12, registered nurse (RN)-A verified the alarm was to be connected and R10's plan of care had not been followed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure preventative measures to reduce/minimize the risk of falls had	2 830		

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2 830	Continued From page 5 been correctly implemented for 1 of 3 residents (R10) identified at risk for falls. In addition they failed to ensure the side rails were fitting the bed appropriately for 2 of 2 residents (R96 and R72) who utilized rails. Findings include: R10's diagnoses included anxiety, depression, general muscle weakness, and he had a history of falls. R10's preventative fall interventions were not applied appropriately according to the plan of care. At 7:10 a.m. on 2/1/12, R10 rested in bed with his wheelchair next to him. The bed was equipped with a sensor pad (a pressure sensitive pad that is connected to call light system that alerts caregiver(s) with audio sound when patient gets out of bed); however, the sensor pad was not connected to the alarm box which prevent it from notifying the staff of any attempts to self transfer. At 8:15 a.m. on 2/2/12, R10 sat up on the edge of his bed and reached for his wheelchair. He was unable to transfer himself a returned to a laying position in the bed. The bed alarm was not observed to sound during that time. At 9:00 a.m. at 2/2/12, nursing assistant (NA)-A entered the room and offered R10 breakfast. R10 refused the meal and remained in bed. NA-A then disconnected the alarm system from the wheelchair and connected the bed alarm to the bed sensor pad. She stated the bed sensor was to be connected to ensure it alerted the staff of R10's potential to transfer himself. The record also contained a Fall Care Area Assessment (CAA) dated 8/10/11, which identified his high risk of falls and directed the	2 830		

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2 830	Continued From page 6 staff to utilize a personal alarm on his bed. The quarterly minimum data set (MDS) dated 1/5/12, identified R10 with cognitive impairments, requiring extensive assistance of one staff for transfer and ambulation. The MDS also identified R10 as having a history of falls. The Fall Risk Assessment dated 1/3/12, identified R10 as a high risk for falls. The plan of care printed on 2/2/12, directed the staff to utilize a personal alarm on his bed which was to be connected into the call light system to alert staff of possible attempts to transfer himself. Review of the progress notes dated 9/1/11-2/2/12, indicated R10 had sustained seven falls without injury. At 12:25 p.m. on 2/2/12, licensed practical nurse (LPN)-D stated R10 had been sitting in his wheelchair when she arrived at the facility at 6:30 a.m. She stated she did not know when he transferred himself to the bed, but stated the bed alarm should have been connected at the time of his transfer. At 12:35 p.m. on 2/2/12, registered nurse (RN)-A stated the alarm system was to be connected to the alarm box to notify the staff of any potential attempts to self transfer. She verified the plan of care had not been followed. At 1:45 p.m. on 2/2/12, the director of nursing verified the bed sensor was to be connected to the alarm box. R96's diagnoses include dementia with behavioral disturbance, anxiety and muscle weakness. R96 had a recent history of falling out of bed, had	2 830		

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2 830	Continued From page 7 bed side rails that were not assessed to determine if they meet the Federal Drug Administrations (FDA) recommendations for safety. A quarterly MDS dated 11/29/11, indicated the resident had a BIMS (Brief Instrument of Mental Status) score of 5 which identified R96 as having a cognitive impairment. The MDS further identified R96 as requiring extensive staff assistance with bed mobility and transfers. The nursing notes from 12/24/11 to 1/29/12, were reviewed. A nursing note dated 12/19/12, indicated R96 had fallen when attempting transfer herself from the bed to the wheelchair. A nursing note dated 12/24/11, indicated that R96 was observed sitting at the side of the bed with her personal alarm was sounding. A nurse assistant was able to reach the resident just before she slide to the floor. A progress note date 1/29/12, by the register nurse manager of the secured unit (RN)-B indicated, "The resident has been assessed to safely use a 1/2 side rail. Resident utilizes a 1/2 rail for bed mobility, repositioning, to support self with sitting up and entering/exiting bed safely. Resident's cognitive status she is confused with a diagnosis of dementia with behaviors, and restlessness she self-transfers and utilized the side rail to safely stand up alone and weight and build indicate no safety risk with use of 1/2 rail. Side rails are secure, rigid and close to the mattress and meet FDA guidelines. The side rail does not impede resident's movements or obstruct the resident's view. Resident wishes to continue utilizing 1/2 side rails."	2 830		

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	00654	A. BUILDING _____ B. WING _____	02/03/2012

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2 830	Continued From page 8 R96's bed was observed at 4:45 p.m. and 7:45 p.m. on 1/30/12, R96 was observed in bed with both side rails in the up position. At 7:30 a.m. on 2/1/12, R96's side rails were measured when the resident was not in bed. FDA guidelines dated 3/2006, recommend that side rails should fit firmly to the mattress and spacing between the bars be limited to prevent entrapment. The FDA recommends zone 2, which was the area under the rail, between the rail supports be less than 4 and 3/4 inches. The area between the rail supports on R96's bed was 7 and 3/4 inches. The FDA recommends that zone 4 which was the area under the rail, at the ends of the rail and the mattress be less the 2 and 3/8 inches. R96 mattress measured 3 and 1/2 inches from the ends of the rail to mattress. In addition, R96 mattress did not fit firmly to the to the bed frame and could slide another two inches away from the side rail. During an interview at 9:17 a.m. on 2/1/12, RN-B indicated R96 had fallen when attempting to exit her bed during the p.m. of 1/31/12, and a curved mattress would be placed on the residents bed. Record review indicated the resident had not sustained an injury. During an interview at 11:50 a.m. on 2/1/12, RN-B was asked about the side rail assessment she had completed on 1/29/12. RN-B verified she had not actually measured R96 rails or assessed the bed to determine if the mattress fit tightly to the rails to determine if they imposed an entrapment risk. RN-B indicated that the maintenance director (M-A) had told her all the	2 830		

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2 830	Continued From page 9 side rails in the facility were FDA approved and that the assessment she completed on the computer charting was a template that she just filled in the blanks. RN-B verified she was unaware of the FDA guide lines published 3/2006. During an interview at 12:10 p.m. on 2/12/12, M-A verified he had not measured or assessed R96 side rails or mattress. M-A indicated the bed was obtained from another sister facility so he just assumed they were safe. R72 bed side rails on her bed that were not assessed to determine if they meet the Federal Drug Administrations (FDA) recommendations for safety. R72's diagnoses include dementia with behavioral disturbance, delusions and psychosis. A quarterly MDS dated 12/30/11, indicated the resident had a BIMS score of 3 which identified R72 as having a cognitive impairment. The MDS further identified R72 as independent with bed mobility and transfers. On the p.m. of 1/30/12, and periods throughout the day on 1/31/12, R72 was observed in bed with two quarter rails in the up position. A progress note dated 1/30/12, by RN-B indicated R72 has been assessed to safely use a ½ side rails. "Resident utilizes a ½ rail for bed mobility, repositioning, to support self with sitting up and entering/exiting bed safely. Resident's cognitive status she is confused with a diagnosis of dementia with behaviors, she self-transfers and utilized the side rail to safely stand up alone and weight and build indicate no safety risk with use of 1/2 rail. Side rails are secure, rigid and close to the mattress and meet FDA guidelines. The side	2 830		

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2 830	Continued From page 10 rail does not impede resident's movements or obstruct the residents view." At 7:45 a.m. on 2/1/12, R72's side rails were measured when the resident was not in bed. The FDA recommends zone 2, which is the area under the rail, between the rail supports be less than 4 and ¾ inches. The area between the rail supports on R72's bed was 7 and ¾ inches. The FDA recommends that zone 4 which was the area under the rail, at the ends of the rail and the mattress be less the 2 and 3/8 inches. R72 mattress measured 3 and 1/2 inches from the ends of the rail to mattress. During an interview at 11:50 a.m. on 2/1/12, RN-B verified she had not measured R72 side rails to determine if they met the FDA recommendation and that she just completed the template because M-A told her all the side rails in the facility met the FDA standards. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents fall intervetions are properly placed. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the	2 900		

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2 900	Continued From page 11 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility failed to comprehensively assess and implement interventions to prevent the development of a new pressure ulcer for 1 of 3 residents (R17) in the sample of residents who had a history of pressure ulcers. Findings include: R17 had the diagnoses which included obstructive hydrocephalus, organic brain syndrome, paralysis agitans (Parkinson's disease), history of pressure ulcers of the toe and heel, convulsions, and mild mental retardation. R17's nose sore was not identified or assessed by the facility staff until the surveyor brought it to the attention of the director of nurses (DON) at 9:54 a.m. on 2/3/12. The DON verified the sore was a Stage 1 pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence) and immediately	2 900		

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2 900	Continued From page 12 reported it to the wound nurse. During an interview at 5:13 p.m. on 1/30/12, R17 told the surveyor that his nose was sore. R17 was thin with a prominent nose that had enlarged prominence's near the bridge area. R17 was wearing glasses that had foam padding along the entire length of the bows, on the left side, the foam had come loose and was just hanging out to the side. At 9:02 a.m. on 2/1/12, R17 was sitting in the dining room with two slices of toast sitting in front of him and his glasses were off and sitting on the table. Licensed practical nurse (LPN)- E encouraged R17 to eat his toast and placed his glasses back on. R17 returned to his room with his toast and remained there until 11:28 a.m. at which time the surveyor again noted that his nose looked very sore. R17 was questioned how his nose area was and to which he replied, "It's kinda sore". The red lump was becoming more red and enlarged. The Annual Minimum Data Set (MDS) on 12/14/11, identified R17 had impairment of memory recall and temporal orientation (to year, month, and day), delusions, and behavioral symptoms of physical abuse directed towards others, rejection of personal cares, verbal abuse of others, and socially inappropriate behaviors. R17 required extensive physical assistance of staff in bed mobility, transfers, dressing, and toilet use, and was unable to walk. R17 was frequently incontinent of urine and occasionally incontinent of bowel and was identified as high risk for pressure ulcer development. Review of the Tissue Tolerance Results report reviewed in the nursing progress notes on	2 900		

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2 900	Continued From page 13 12/8/11, revealed that R17 was at risk for skin breakdown related to poor dietary intake, mobility, friction and shear forces, and incontinence. The assessment indicated, "Staff will continue to assist patient with personal cares and observe for breakdown in tissue." The Care Area Assessment (CAA), Analysis of Findings regarding Pressure Ulcers on 12/21/11, identified that R17 was at risk for skin breakdown related to co-morbidities, chronic edema, decreased mobility, confusion, and incontinence. Review of the West Wind Village Care Guide dated 2/1/12, for R17, under the Vision section identified the intervention of "Foam on bows of glasses to prevent breakdown." The care guide did not identify the sore on the left side on the bridge of the nose, nor were interventions developed for treatment and protection of the area to prevent further breakdown. Review of the Care Planning Report effective date 2/2/12, identified R17 was at risk for skin breakdown related to decreased mobility, increased confusion, lethargy, and incontinence of bowel and bladder. The care plan indicated R17 had a history of Stage 1 pressure ulcer to the right heel and stage two pressure ulcer to the right great toe. Interventions included: "Ensure foam pieces stay on glasses to relieve pressure bid which started 11/6/09. Weekly skin check with bath which was approved 3/25/10. Monitor for skin redness which was approved 5/11/11." Vision was identified as a problem and had the intervention of "Foam on bows of glasses to prevent breakdown which was approved 3/24/10." Nursing assistant (NA)-D was interviewed at 11:50 a.m. on 2/2/12, and reported the nurses	2 900		

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2 900	Continued From page 14 aides (NA's) are to notify the team leader or the floor nurse if they see a skin issue. NA-D stated the skin assessments are completed weekly with the resident's bath and they are to report any changes in skin that are noted. At 11:31 a.m. on 2/2/12, Clinical Manager (CM)-A verified nothing had been charted on R17's last weekly skin assessment. CM-A commented, "I will ask my staff nurse what she knows and then [will] get back to you." After CM-A spoke with the staff nurse she concluded R17 had behaviors related to his bi-pap (a mask worn at night for sleep apnea) which she believed may have caused the nose sore. She revealed that R17 moves it around on his face or throws it on the floor. CM-A acknowledged R17's current skin assessments did not reflect the sore on his nose, how it developed, or what interventions should be implemented for treatment and prevention of further deterioration of the skin. At 9:54 a.m. on 2/2/12, the DON assessed R17's nose and verified the sore was a Stage 1 pressure ulcer caused by pressure from R17's glasses rubbing on his nose. The DON verified R17's new skin problem should have been noted on the most current skin assessment and acknowledged that it had been overlooked by all staff. The DON stated nursing interventions should have been developed for treatment and prevention of further skin breakdown. The Wound Nurse assessed R17 at 10:00 a.m. on 2/3/12, verified the cause of the Stage 1 pressure ulcer of the nose was related to the prong on R17's glasses being pushed in. The wound nurse stated she would immediately notify the doctor and implement daily monitoring of the skin area and the prongs on R17's glasses.	2 900		

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2 900	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to store, prepare, distribute and serve food under sanitary conditions which had the potential to affect 83 of 83 residents in the sample. Findings include: The facility did not ensure food was served under sanitary conditions for the meal service on 1/30/12. At 5:15 p.m. on 1/30/12, the evening meal was	21000		

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21000	Continued From page 16 served to the 38 residents and one family member in the main dining room. The steam table was set up with two meal choices. The first choice was a polish sausage and boiled cabbage. The second choice was cream of asparagus soup and a grilled cheese sandwich. Cook-A wore gloves as she served the meal. At 5:19 p.m. cook-A picked up a glass, opened the refrigerator, removed a gallon of milk, poured it into the glass, replaced the milk and shut the door. She then was observed to go back to the steam table and dished up a bowl of soup and reached into the steam table with her soiled gloved hand, picked up a sandwich, placed it on the plate and set it up on the counter for the nursing staff to deliver it a resident. At 5:23 p.m. cook-A rubbed her nose with the back of her soiled gloved hand. She was not observed to change her gloves or wash her hands as she continued to dish the meals for the residents. At 5:25 p.m. cook-A walked around the steam table area, removed the coffee pot filter, carried it behind the counter, placed a new filter and grounds, replaced the filter into the coffee machine and pushed the button to start it. She then returned to the steam table, dished another meal for a resident again reaching directly into the container of grilled cheese sandwiches and touched the sandwich with her soiled gloved hand as she placed it onto the plate. At 5:27 p.m. licensed practical nurse (LPN)-C walked into the kitchenette area, opened the refrigerator, removed a gallon of milk and poured a glass of milk. She then replaced the milk in the refrigerator. At 5:28 p.m. cook-A opened the fridge with her soiled gloved hand and removed a plate from the	21000		

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21000	Continued From page 17 refrigerator and handed it to a nursing staff member to deliver to a resident. She then continued to serve meals from the steam table, each time reaching directly into the container of grilled cheese sandwiches with her soiled gloved hand. At 5:30 p.m. nursing assistant (NA)-C asked cook-A for a specialized cup. Cook-A wore the same soiled gloves as she opened the door to the kitchen and momentarily returned with a cup. She was not observed to wash her hands or change her gloves after touching the kitchen door. Cook-A continued to dish up meals for the residents, directly touching the sandwiches. At 5:37 p.m. cook-A opened the door to the kitchen with her soiled gloved hands and returned with another cup. She again returned to the steam table and dished up meals for the residents without changing her soiled gloves or washing her hands. At 5:40 p.m. cook-A removed the items from the steam table, removed her gloves and washed her hands in a sink located behind the steam table. That was the first time the cook had removed her gloves during the entire meal service. SUGGESTED METHOD OF CORRECTION: The Director of Dietary Services could develop a policy and procedure to ensure that food was served in a safe manner. Staff could receive training regarding handwashing and glove use to ensure knowledge of safe food handling while serving residents. Monitoring could occur to ensure food was served in a safe and sanitary manner. TIME PERIOD FOR CORRECTION: Thirty (30)	21000		

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21000	Continued From page 18 days.	21000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to store, prepare, distribute and serve food under sanitary conditions which had the potential to affect 83 of 83 residents in the sample. Findings include: During the initial kitchen environment inspection at 2:00 p.m. on 1/30/12, the following findings were noted. The the side by side refrigerator and freezer in the kitchen food preparation area was noted to have excess dust and debris on top of them that was noted to fall off in balls of dust when a hand was raked across the top. The large mixer bowl was noted to have a large amount of dried food particles on the agitator arm and arm assembly. The food debris was noted to be caked on around the bolt that secured the agitator arm to the motor unit. The Dietary manager stated the mixer was used daily and had not been used yet today. All air flow vents (heater/exhaust) in the kitchen	21015		

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21015	Continued From page 19 where noted to be heavily covered with dust and the dust was noted to be hanging from them directly over food preparation and food service areas. The commercial grade can opener, on the food preparation counter, was noted to be heavily soiled around and behind the cutting blade and the blade assembly where it mounted to the unit motor. The facility had a commercial grade electric potato peeler that was noted to have excess mineral deposit on the peeling plate (internal plate that came in direct contact with food). The opening at the top of the peeler had mineral buildup that was noted to be flaking off and falling into the peeler unit. During the inspection the dietary manager was present and verified the findings. The dietary manager stated the maintenance department was responsible for cleaning high areas and stated she had a schedule for cleaning the mixer and can opener. the director stated she was not sure what to do about the potato peeler as it was unable to be cleaned. At 9:30 a.m. on 2/1/12, the kitchen environment was inspected with the maintenance director and his assistant. During the inspection the vents and high areas (refrigerator/freezer tops, light fixtures and ceiling vents) in the kitchen continued to be heavily soiled. The maintenance director verified the findings and stated maintenance was responsible for cleaning the vents and light fixtures but the kitchen personnel where responsible to clean the tops of food storage units. The director verified the findings on the potato peeler and stated the only way for it to be	21015		

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21015	Continued From page 20 cleaned was to purchase another internal plate for the unit. The maintenance director stated there was a cleaning schedule for the vents and light fixtures to be cleaned monthly but verified if they had been cleaned the cleaning schedule was ineffective and the cleaning needed to be done more frequently. At 11:45 a.m. on 2/2/12, the noon meal was observed for preparation and service. during the observation it was noted that all of the concerns identified on 1/30/12 during the initial inspection continued to be present. The facility failed to have a system in place to ensure food was stored, prepared and distributed under sanitary conditions. A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is stored and served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences	21535		

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21535	Continued From page 21 which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on document review, and staff interview, the facility failed to identify drug irregularities for dosing requirements and adequate indications for use or continued need of antihistamine medication in the presence of adverse reactions as recommended by the consultant pharmacist for 1 of 10 (R67) residents in the sample reviewed for the use of unnecessary medications. Findings include: R67 continued to receive Tylenol PM (used to treat pain and help you fall to sleep) on an as needed basis (PRN) without supporting diagnosis for need or rationale for continued use despite potential adverse side effects which included syncope episodes (fainting). In addition, the medication order did not include the drug dosage to be administered. R67 had diagnoses which included Parkinson's	21535		

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21535	Continued From page 22 disease, orthostatic hypotension (blood pressure dropping upon standing), hypotension (low blood pressure), syncope with collapse (fainting spells), sleep apnea, and anemia with recent blood transfusions. The Annual Minimum Data Set (MDS) on 12/22/11, identified that R67 was alert and oriented, had indicators of depression including feeling tired or having little energy nearly every day and trouble staying asleep or sleeping too much. R67 required extensive staff assistance with bed mobility, transfers, dressing, and toilet use. Review of the behavior summary on 12/22/11, revealed, "Patient appears to sleep well. Patient does not receive pharmalogical or nonpharmacological interventions for sleep." The summary did not identify that R67 used the Tylenol PM for sleep. The Care Area Assessment (CAA) on 12/28/11, identified adverse medication consequences of increased risk for falls, postural hypotension, orthostatic hypotension, lethargy, mental depression, and disturbances of balance. Review of Progress Notes from 11/11, through 2/12, indicated R67 had orthostatic changes (drops in blood pressure) with "occ (occasional) spells of low BP (blood pressure), unresponsive spells on toilet." Review of the nurses notes identified the spells would last from 10-45 seconds with R67's eyes closed and arms going limp. The Care Guide dated 2/2/12, identified safety concerns of "Severe postural hypotension, especially with bowel movements, MUST STAY	21535		

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21535	Continued From page 23 IN ROOM WHILE RESIDENT IS IN THE BATHROOM. DO NOT LEAVE ALONE." On 11/18/11, the consultant pharmacist made recommendations to discontinue Tylenol PM due to minimal effectiveness and R67 experiencing the potential side effects of "weird dreams, dry mouth, and also woke up not feeling well." R67 also experienced stiffness and shaking. Staff had reported the effectiveness of the medication as "hit and miss." Review of the physician's progress notes, physician's orders, and the Medication Administration Records (MAR) revealed R67 continued to take the medication on a PRN basis without physician review for adequate indications for use and continued need despite potential adverse side effects. Review of the current Physician's Orders (no date indicated on computer copy) identified that Tylenol PM Extra strength, 2 tabs was ordered to be given at night on a PRN basis. The order read, "continuous prn repeating." The order did not specify a diagnosis for use nor did it clarify the specific amount of medication per tablet. Each tablet contained an amount of Tylenol and an amount of Benadryl (diphenhydramine), but the order did not indicate exact amounts to be given besides, "2 tabs". Review of the Medical Records Information form revealed R67's physician examined R67 on 12/1/11, and 1/25/12, and did not evaluate the continued need for Tylenol PM as recommended by the consultant pharmacist on 11/18/11. At 9:37 a.m. on 2/3/12, Clinical Manager (CM)-A acknowledged the medication should have been reviewed as recommended by the consultant pharmacist but added, "R67 does what she	21535		

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21535	Continued From page 24 wants; [the doctor] never discontinued it." CM-A verified the physician should have included a risk versus benefit statement if he wanted her to continue on the medication. Interview with the director of nurses at 10:00 a.m. on 2/3/12, verified that it was the expectation of the nursing staff to review the pharmacy recommendations and to update the physician if irregularities are identified. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	21685		

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21685	Continued From page 25 Findings include: During the initial kitchen environment inspection at 2:00 p.m. on 1/30/12, the following findings were noted. All air flow vents (heater/exhaust) in the kitchen where noted to be heavily covered with dust and the dust was noted to be hanging from them. The vent were noted to be located over food preparation areas and also areas outside of the food preparation area. Light fixture covers were noted to have excess dust hanging from the side which could be easily visualized when walking into the kitchen area. During the inspection the dietary manager was present and verified the findings. The dietary manager stated the maintenance department was responsible for cleaning high areas. At 9:30 a.m. on 2/1/12, the kitchen environment was inspected with the maintenance director and his assistant. During the inspection the vents and high areas (refrigerator/freezer tops, light fixtures and ceiling vents) in the kitchen continued to be heavily soiled. The maintenance director verified the findings and stated maintenance was responsible for cleaning the vents and light fixtures but the kitchen personnel where responsible to clean the tops of food storage units. The maintenance director stated there was a cleaning schedule for the vents and light fixtures to be cleaned monthly but verified if they had been cleaned the cleaning schedule was ineffective and the cleaning needed to be done more frequently. The facility failed to have ensure a a safe,	21685		

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21685	Continued From page 26 functional, sanitary, and comfortable environment for residents, staff and the public. SUGGESTED METHOD OF CORRECTION: The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable and homelike manner. Ongoing maintenance, monitoring and record keeping to ensure that the environment, including resident rooms and equipment are maintained to eliminate offensive odors. Develop a system to audit the environment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21685		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide maintenance and housekeeping services to maintain hallways, resident rooms, resident bathrooms, tub rooms and resident equipment in a safe and sanitary manner in 4 of the 5 units. This had the potential to affect 72 of 83 residents in the facility.	21695		

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21695	Continued From page 27 Findings include: During the environmental tour at 2:00 p.m. on 2/2/12, with the administrator, director of nursing (DON), maintenance director (M-A) and housekeeping supervisor (HK-A) and throughout the survey the following was noted. The hallways on the Park Avenue, Pacific, Atlantic and Main unit were stained with black build up along the base boards and resident room door thresholds. The tile flooring had cracks and gaps that collected debris and were an unclean able surface. M-A verified that the blacken areas in the hallways were wax build up and that he had not tried to strip them. The administrator verified that the tile was in disrepair and unclean able. At approximately 2:25 p.m. on 2/2/12, it was observed, with the DON present, that five toothbrushes were lying directly on a shelf under the mirror in the bathroom in resident room #113. The shelf was dusty and had brown stains. The DON verified at that time that residents tooth brush should not be stored in such a manner. On the Pacific Unit resident rooms #159, #176, #177, #178, and #180 had cracks in the walls and under the windows. M-A indicated the cracks were due to the building shifting and that there was nothing he could do about it. M-A further indicated if he filled the crack and painted over them the cracks would reappear. Dirty and dusty bathroom exhaust vents where noted in resident rooms #104, #119, #126, # 128, #131, #133, #139, #141, #142, #145, #154, and #177.	21695		

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21695	Continued From page 28 Dirty floors were noted in resident rooms and bathrooms: #102, #104, #106, #108, #112, #142, and #180. Chipped veneer on closet doors and chipped wall paint were noted in rooms #102, #105, #126, #139, #142, #154, and #159. The Nostalgic family room at the end of the main unit had stained carpeting and the heating vent was noted to have black scuff marks. The vents were rusty and had a dusty build up. M-A verified that the carpet was stained and the heating vent required cleaning. The tub rooms on the Atlantic and Pacific wing had cracked and missing tile on the floor. Both tub rooms had yellow stains under the tub. The Atlantic tub room and an area of missing plaster on the wall at the foot of the tub that was approximately two feet by one foot in size. On the Pacific unit 2 of 2 mechanical lifts were noted to have a heavy buildup of food debris on the foot boards. In addition, one of the lifts had torn vinyl on both side bars that the residents hold on to during transfers. The DON verified at approximately 2:35 p.m. on 2/12/12, that the lifts should be cleaned weekly and that she was unaware of the torn vinyl. During an interview at 3:00 p.m. on 2/12/12, M-A indicated if staff had maintenance concerns they would fill out a maintenance request form. M-A verified he did not have any current requesting regarding the flooring or chipped veneer and paint. M-A further indicated that it was an old building and something's would have to be replaced. The entrance in to the Park Avenue area had a	21695		

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21695	Continued From page 29 sitting area that contained plastic flowers on the floor and plastic tree branches on the walls and ceiling. At 9:30 a.m. on 2/3/12, the area was observed with HK-A. The branches hanging from the ceiling were noted to be dusty and the base on the brick surrounding the plastic plants was noted to also be dusty and to have a heavy buildup of debris at the base of the bricks and flooring. HK-A verified the findings and indicated that staff clean that area when there is extra time. Review of the facility's Housekeeping Wing Assignment policy dated 11/1/11, indicated that when three housekeepers are on duty, individual daily room cleaning should include: a> Floors (sweep and mop) b> Dusting (TV, Tables, air vents Etc.) c> Toilet d> Garbage e> Under the bed f> Visual inspection of ceiling and walls and cleaning spots g> Window blinds The policy further indicated that if four housekeepers were on duty or if extra time was available, that staff should dust the foliage, vacuum and greens (plastic plants) and clean air vents in the hallways and resident rooms. The policy also specified instructions for when there are only one or two housekeepers available. HK-A indicated at 9:35 a.m. on 2/2/12, the facility tried to have three housekeepers on during the day shift. R10's room was not kept in a clean and sanitary manner.	21695		

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21695	Continued From page 30 At 4:30 p.m. on 1/30/12, R10's family member stated she frequently cleaned the floor R10's room because he would spit and she would frequently find sputum on the floor. At 7:10 a.m. on 2/1/12, R10 rested in bed. The floor was noted to have five areas which contained a dried green material. The areas ranged from the size of a dime to half dollar size. At 9:00 a.m. nursing assistant (NA)-A entered the room and delivered a breakfast tray to R10. She was not observed to remove the matter from the floor. At 9:30 a.m. licensed practical nurse (LPN)-D assisted R10 with his morning cares. When she had left the room, the matter on the floor was untouched. At 12:45 p.m. NA-A stated R10 had a history of spitting on the floor and the staff encouraged him to use tissues. She stated if she noticed any concerns with the floor, she would clean them up. At 1:30 p.m. R10's floor continued to have dried sputum on the floor. At 8:30 a.m. on 2/2/12, R10's floor was clean. At 12:00 p.m. on 2/2/12, housekeeper-B stated R10 frequently has sputum on his floor. She stated R10's room was cleaned daily. She further commented if any concerns are identified in-between cleaning, the staff member who identified the concerns were to clean the area or alert the housekeeping staff. At 12:35 p.m. on 2/2/12, registered nurse (RN)-A stated if a concern was identified on the floor, the	21695		

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21695	Continued From page 31 staff member noticing the concern should assist in cleaning it or alerting the housekeeping staff. At 1:45 p.m. on 2/2/12, the DON verified the floors were to be cleaned as soon as a concern was identified. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing, Housekeeping and/or designee could monitor to assure the facility is clean, sanitary and well maintained. The quality assurance committee could designate staff members to perform random audits to ensure the facility is in compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.	21990		

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21990	Continued From page 32 This MN Requirement is not met as evidenced by: Based on document review and staff interview, the facility failed to timely report potential allegations of abuse and neglect to the administrator and stage agency according to as directed in the facility abuse policy. This affected 4 of 4 residents (R4, R80, R69 and R122) involved in reportable incidents. Findings include: An incident report dated 12/2/11, revealed resident to resident altercations had occurred. On 12/1/11, at 2:00 p.m. R80 struck R4 and threatened R69 by stating he was going to "punch him out, smash his head in." The report indicated the state agency had been notified on 12/2/11 (time unknown), but the administrator had not been notified. An incident report at 1:40 p.m. on dated 1/23/12, revealed R122 had sustained a fall and his fall interventions had not been in place according to his plan of care. The facility notified the administrator and the state agency on 1/30/12, seven days after the incident occurred. Review of the facility Abuse Prevention Policy updated 1/12, directed the staff to immediately report any allegations of abuse and neglect to the administrator and the state agency. At 9:30 a.m. on 2/2/12, the director of nursing (DON) stated the facility policy to report immediately to the administrator and the state agency had been updated within the last three weeks. She stated since the time of the policy update, the facility had not had any type of	21990		

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21990	Continued From page 33 reportable incidents. She reviewed the resident to resident altercation incident and verified the administrator had not been notified timely. She stated she was sure that he had been notified but was unsure of when. She then reviewed the incident involving R122. She stated the computers had not been working properly on 1/23/12, and she was not able to complete the investigation timely. She verified the administrator and the state agency had not been notified until seven days after the event. She verified the facility policy had not been followed. At 4:00 p.m. on 2/2/12, the DON provided a copy of an email at 4:30 p.m. on 12/2/11, from the state agency which had been sent to the administrator notifying him of the received incident report involving R4, R80 and R69. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21990		