

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JJ6G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00654

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245262		3. NAME AND ADDRESS OF FACILITY (L3) WEST WIND VILLAGE (L4) 1001 SCOTTS AVENUE (L5) MORRIS, MN (L6) 56267		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) 482343500		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 03/02/2015 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 06/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)			
12. Total Facility Beds 80 (L18)		13. Total Certified Beds 80 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 80 (L37) (L38) (L39) (L42) (L43)	
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)					

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

See Attached Remarks

17. SURVEYOR SIGNATURE <u>Lyla Burkman, HFE NEII</u> (L19)	Date : 03/02/2015 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Mark Meath, Enforcement Specialist</u> (L20)	Date: 03/09/2015 (L20)
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 09/01/1983 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 02/19/2015 (L33)		DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

Page 2
Provider Number: 24-5262
Item 16 Continuation for CMS-1539

Effective February 26, 2015, eleven beds which were previously on layaway status are permanently decertified in accordance with the delicensure of these same eleven beds.
The number of Medicare Certified beds remains at 80 SNF/NF beds. Please refer to the letter dated February 24, 2015 from Michael Syltie, Administrator.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245262

March 9, 2015

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 February 17, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

A handwritten signature in black ink, which appears to read "Mark Meath".

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 2, 2015

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

RE: Project Number S5262027

Dear Mr. Syltie:

On January 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 8, 2015 that included an investigation of complaint number . 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 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 23, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 17, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 8, 2015, effective February 17, 2015 and therefore remedies outlined in our letter to you dated January 27, 2015, will not be imposed.

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

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

Sincerely,

A handwritten signature in black ink that reads "Mark Meath". The signature is written in a cursive, slightly slanted style.

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5262r15

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 245262	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/2/2015
Name of Facility WEST WIND VILLAGE		Street Address, City, State, Zip Code 1001 SCOTTS AVENUE MORRIS, MN 56267

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC _____	Correction Completed 02/17/2015	ID Prefix F0463 Reg. # 483.70(f) LSC _____	Correction Completed 02/17/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ LB/mm	Date: 03/02/2015	Signature of Surveyor: 28035	Date: 03/02/2015
Reviewed By _____ CMS RO	Reviewed By _____	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/8/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Post-Certification Revisit Report

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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ PS/mm	Date: 03/02/2015	Signature of Surveyor: 34764	Date: 03/02/2015		
Reviewed By _____ CMS RO	Reviewed By _____	Date:	Signature of Surveyor:	Date:		
Followup to Survey Completed on: 1/8/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245262	Provider/Supplier Name WEST WIND VILLAGE
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Type of Survey (select all that apply)

I	D			
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 28035	03/02/2015	03/02/2015	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.25

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

3.25

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number 245262	Provider/Supplier Name WEST WIND VILLAGE
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Type of Survey (select all that apply):

D					
---	--	--	--	--	--

A Complaint Investigation E Initial Certification I Recertification
B Dumping Investigation F Inspection of Care J Sanction/Hearing
C Federal Monitoring G Validation K State License
D Follow-up Visit H Life safety Code L Chow

Extent of Survey (Select all that apply):

A					
---	--	--	--	--	--

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Team Leader 1. 34764	02/23/2015	02/23/2015	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey?

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JJ6G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00654

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245262		3. NAME AND ADDRESS OF FACILITY (L3) WEST WIND VILLAGE (L4) 1001 SCOTTS AVENUE (L5) MORRIS, MN (L6) 56267		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 482343500		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 01/08/2015 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 06/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room			
12.Total Facility Beds 80 (L18)		X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
13.Total Certified Beds 80 (L17)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 80 (L37) (L38) (L39) (L42) (L43)				15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	

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

17. SURVEYOR SIGNATURE <u>Rebecca Haberle, HFE NEII</u> (L19)		Date : 02/10/2015	18. STATE SURVEY AGENCY APPROVAL <u>Mark Meath, Enforcement Specialist</u> (L20)		Date: 02/13/2015
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
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28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28)		30. REMARKS (L31)	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 27, 2015

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

RE: Project Number S5262026

Dear Mr. Syltie:

On January 8, 2015, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

**Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us**

Phone: (218) 332-5140

Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 17, 2015, 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 February 17, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 8, 2015 (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 July 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

West Wind Village

January 27, 2015

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

Sincerely,

Mark Meath, Enforcement Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

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

PRINTED: 02/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2015
NAME OF PROVIDER OR SUPPLIER WEST WIND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SCOTTS AVENUE MORRIS, MN 56267		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157			2/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/02/2015

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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the physician of unusual bleeding for 1 of 7 residents (R10) who received Coumadin. Findings include: The annual Minimum Data Set (MDS) dated 8/7/14, identified R10 had a diagnosis of atrial fibrillation and received anticoagulant medication 7 out of 7 days, had moderate cognitive impairment, needed memory cues and needed physical assistance with activities of daily living (ADLs.) Review of R10's quarterly MDS dated 11/5/14, also identified R10 as receiving anticoagulant medication 7 out of 7 days, had mild cognitive impairment needing memory cues and needed physical assist with ADLs. Review of R10's Care Area Assessment (CAA) summary note dated 8/21/14, identified R10 was at risk for bruising and received Coumadin (a blood thinner) 3.5 milligrams (mg) by mouth daily for atrial fibrillation.	F 157	F157 West Wind Village will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. West Wind Villages Policy ☐ Notification of Changes Affecting Residents was updated to include uncontrollable		

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F 157	Continued From page 2 Review of R10's care plan dated 9/29/14, identified R10 was on an anticoagulant therapy alert. R10's care plan directed facility staff to monitor for signs and symptoms of bleeding, protect from injury and to wear arm protectors daily due to frequent bruising from bumping arms. Review of R10's current physician orders signed 11/13/14, revealed R10 was ordered Coumadin 3.5 mg by mouth one time per day at 20:00 for atrial fibrillation. Review of R10's electronic medication administration record (EMAR) monthly reports from October 2014 to January 2015, revealed R10 received a daily dose of Coumadin 3.5 mg daily. Review of R10's progress notes revealed on 1/03/2015, R10 had a nose bleed from the left nostril and had expectorated large clots from the mouth. The note further revealed R10 had verbalized concern over the nose bleed and R10 had stated, " I don't want to bleed to death." Facility staff had applied pressure to the nostril. The facility progress note also revealed R10's nose bleed lasted 45 minutes and R10 had received Coumadin ten minutes prior to the bleed. The facility progress note lacked any further information regarding R10's nose bleed. On 01/05/2015, at 6:17 p.m. R10 was observed seated in a wheelchair in the hallway with a white kleenex in her left nostril. R10 stated that was her third bloody nose in the last few days. R10 also stated one night the bloody nose lasted a long time and the nurse had to pack her nose. R10 stated despite the nurse packing her nose it	F 157	nosebleed and unusual bleeding when resident is on an anticoagulant to the example list of when to notify the physician/responsible family member. All nursing staff will be re-educated February 4th, 2015 on the updated policy and the importance of updating the physician, legal representative or an interested family member. All residents who have sustained an accident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility will have their EMR audited to ensure the resident's physician, resident's legal representative or an interested family member was informed of the change in status. Audits will be conducted by the DON/designee 2x/week x4, weekly x4 and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations.		

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F 157	Continued From page 3 continued to bleed which concerned her. R10 stated that she took a blood thinning medication daily and did not want to bleed to death. R10 further stated the facility staff was aware of the bloody noses though R10 was unaware if her physician was aware. On 1/6/2015, at 9:00 a.m. R10 was observed seated in a wheelchair in the hallway with a white tissue stuffed in the left nostril. R10 stated she had a really small nose bleed and the facility nurses were aware though was not sure what they were doing about the nose bleeds. R10 was not aware of any other interventions tried by the facility nurses other than packing the nostril. On 1/7/15, at 12:45 p.m. R10 stated she had taken the blood thinning medication for many years. R10 had no concerns overall with her medications, though she did have concerns with the nose bleeds that had been occurring for the past few days. R10 stated the facility staff had to "pack her nose" to get the bleeding to stop though the bleeding had continued beyond the packing. R10 stated she was aware she could develop bleeding from the Coumadin. On 01/07/15, at 1:50 p.m. licensed practical nurse (LPN)-A stated R10 was at risk for bruising and bleeding due to long term Coumadin use. LPN-A also stated R10 had occasional nose bleeds though did pick at her nose at times. LPN-A stated she felt none of R10's nose bleeds had seemed life threatening that had been observed by her. LPN-A verbalized if R10 had a prolonged nose bleed or if clots were present she would notify the nurse manager and the physician would also be notified.	F 157			

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F 157	Continued From page 4 On 01/08/15, at 10:10 a.m. registered nurse (RN)-A confirmed R10's progress note on 1/3/15, and stated R10's nose bleed should have been reported to the physician as the bleeding lasted 45 minutes as well as clots had been present as well. RN-A stated R10 was at risk for hemorrhage due to daily and prolonged use of Coumadin. RN-A stated she expected the facility nursing staff to notify residents physician with changes in condition, which R10's nose bleed should have been reported due to how long it lasted. On 1/8/15, 12:10 p.m. RN-A stated she had notified R10's physician of the nose bleeds. R10's physician responded to check R10's PT/INR (prothrombin time/international normalized ratio-blood test to determine clotting tendency of the blood) on 1/19/15, continue with medications and interventions. Facility policy titled, West Wind Village Notification of Changes Affecting Residents, dated 3/13, directed facility staff that the charge nurse would notify the resident, physician, or responsible family member for any of the following situations, included medication related adverse reactions. A facility policy titled, West Wind Village Notification of Changes -Physician Notification dated 3/13, revealed a procedure which directed facility staff to notify a residents physician with changes in health status.	F 157			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system	F 463			2/17/15

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F 463	Continued From page 5 from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to implement a system to ensure call lights were functioning in resident rooms for 2 of 33 residents (R98, R5) reviewed in the stage 1 sample. Findings Include: On 1/6/15, at 9:03 a.m. R98's call light was observed mounted on the wall near the resident's bed and when activated, was found to be not functioning. Licensed practical nurse (LPN)-B entered R98's room at surveyor request, and verified the call light was not functioning. LPN-B indicated the facility call lights for residents were not routinely monitored to ensure they were functioning. LPN-B stated the staff does not know they are broken until someone tries to use the call light. LPN-B indicated the battery in the call light box may not be working. During observation on 1/6/15, at 9:55 a.m. R5's call light was laying on the floor beside the resident's bed and the call light did not activate when call light triggered. LPN- B entered R5's room at request of surveyor and verified the call light was not functioning. LPN-B indicated it was common to need to replace batteries in the individual call lights for residents. On 1/7/15, at 11:55 a.m. the director of environmental services (DES) stated each call light unit utilized a battery to operate. The DES	F 463	West Wind Village will ensure the call lights are functioning properly in the facility. West Wind Village uses the Arial Call Light System. The system is monitored on a main computer. There is an Alerts function/ program within the system that monitors the battery level of each call light and each device as it is paired with its location. The Director of Environmental Services (DES) or designee will check the Arial Alert program daily to ensure proper functioning of the system. As alerts arise, they will be immediately fixed by the DES or designee. DES will maintain a log of repairs by maintenance of the call light system. Nursing staff will be trained on February 4, 2015 on the importance of notifying the Environmental Services department for any call-lights that are not functioning properly. Results of maintenance daily audits and logs of repairs will be brought to the QAPI committee for review and further recommendations.		

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F 463	Continued From page 6 confirmed the facility maintenance staff did not routinely monitor the call light system and stated they did not maintain a log of repairs of maintenance of the call light system. On 1/7/15, at 12:00 p.m. maintenance aide (MA) stated the facility staff did not routinely complete inspections of the resident call light system. On 1/8/15, at 2:53 p.m. DES confirmed the facility had not developed a policy for routine inspections of the resident call light system and indicated he would contact the facility administrator in the near future to work on this.	F 463	A policy will be written and approved by the QAPI committee to reflect the above.		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, West Wind Village was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000			

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/02/2015

Electronically Signed

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The West Wind Village was constructed at four different times. The original building was built in the 1962, is 1- story, with a basement and was determined to be of a Type V (111) construction because of wood found in parts of the roof system and an outside storage room that was added to the southeast of the East Wing. In 1972 additions were constructed to the west and east of original building. They are 1-story, without a basement, and were determined to be Type II (000) construction. In 1976 an addition was built to the northwest of the original building, is 1 story without a basement and was determined to be Type II (000) construction. In 1999 a secured unit was added to the northwest addition and is 1-story without a basement and was determined to be Type II(000). The building is divided into 6 smoke zones on the main floor. An automatic fire sprinkler system is installed throughout the building in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The building has a fire	K 000			

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K 000	Continued From page 2 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 80 beds and had a census of 74 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 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the	K 144			2/17/15
			West Wind Village will immediately document its generator logs as directed by the State Fire Marshal and as directed		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2015
NAME OF PROVIDER OR SUPPLIER WEST WIND VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 SCOTTS AVENUE MORRIS, MN 56267		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 3 requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 74 residents. Findings include: On facility tour between 4:30pm and 7:30 PM on 11/05/2014, documentation review of the weekly inspection logs of the diesel generator showed incomplete emergency generator testing requirements for 2014. This deficient practice was confirmed by the Director of Environmental Services (GB) at the time of discovery.	K 144	by the 2000 NFPA 101 ☐ 9.1.3 and 1999 NFPA 110 Chapter 6-4-1 to show actual generator values (oil level, battery electrolytes, water temp, etc.).		