Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
West Wind Village
1001 Scotts Avenue
Morris, MN 56267
Stevens County

Report #: H5262015

Date: March 14, 2013

Date of Visit: August 30, 2012
Time of Visit: 7:30 a.m.- 5:00 p.m.

By: Lisa Ciesinski, R.N., Special Investigator

Type of Facility:

☒ Nursing Home
☐ HHA
☐ Home Care Provider/Assisted Living
☐ SLF
☐ ICF/IID
☐ Home Care
☐ Hospital
☐ Other: ____________

☒ Facility Self Report ☐ Complaint

Allegation(s): The allegation is neglect based on the following: A resident choked and was sent to the hospital with aspiration pneumonia after a nursing assistant, and kitchen staff gave the resident a salad with cucumbers. The resident's care plan called for a mechanical soft diet.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

- [ ] State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- [ ] State Licensing Rules for Home Care (MN Rules Chapter 4668)
- [ ] State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect is substantiated. The resident was served food that was not included on the resident's specialized diet, which resulted in the resident choking on a piece of raw cucumber.

Documentation and interviews established that the resident had a history of swallowing difficulties and choking episodes. Approximately 2 weeks prior to the incident, the resident was hospitalized with aspiration pneumonia (inflammation of the lungs and airways to the lungs from breathing in foreign material) after choking on a hot dog. The resident returned to the facility on a mechanical soft (diet used for people who have difficulty in chewing or swallowing) with no hot dog diet. The resident was confused with memory loss.

Documentation and interviews revealed that during a lunch meal the resident requested a salad, which included lettuce and raw cucumbers. The resident's diet card was located at the resident's table, and indicated the resident was to receive a mechanical soft diet. Staff did not verify the resident's diet, and served the resident a salad with raw cucumbers, which was not allowed on the resident's mechanical soft diet. The resident began to choke, and became unconscious. Staff performed the Heimlich maneuver, abdominal thrusts, and called 911. The paramedics arrived and used forceps to remove a large piece of cucumber from the resident's throat. The paramedics transported the resident to the hospital. The resident received oxygen therapy during the transport, and at the hospital. The resident remained hospitalized for 4 days with a diagnosis of aspiration pneumonia.

Due to cognitive deficits, the resident was not able to be interviewed.

Staff interviews revealed the staff assisting the residents did not consistently place the diet card on the buffet table for the dietary staff plating the residents' meals to review, and the dietary staff plating the residents' meals did not consistently review the residents' diet cards to verify the residents' diet orders.

The facility's mechanical soft diet guidelines indicate that raw vegetables are not allowed on a mechanical soft diet. The facility policy regarding meal service indicates that during lunch, each resident has a diet card placed at the resident's table, which indicates what diet the resident is to receive. The staff assisting the resident writes the resident's meal choice on the diet card and places the card on the buffet table. The dietary staff plating the food then reviews the diet card, along with the resident's meal preferences, and provides a meal for the resident that is consistent with the resident's prescribed diet. Diet cards are to be reviewed at each meal; however, the

procedure for reviewing the diet cards at breakfast is not consistent with lunch and dinner.

During the onsite visit, breakfast dining room observations revealed although the residents received the correct diets, the staff did not use the residents' diet cards to verify the residents' diets prior to providing or serving the residents' meals.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:
Although the facility had policies and procedures in place to ensure that residents receive the correct diet, staff did not consistently follow the policy. There was no evidence that AP#2 received training on the diet card process.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: ___________
(The 2567 will be available on the MDH website.)

State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655) – Compliance Not Met
The requirements under State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):
An unannounced follow up visit was conducted at the facility on November 21, 2012. The facility was found to be back in compliance with federal and state regulations for long term facilities.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records
☒ Medication Administration Records
☒ Facility Incident Reports
☐ ADL (Activities of Daily Living) Flow Sheets
☒ Physician Orders
☒ Nurses Notes
☐ Activities Reports
☐ Therapy and/or Ancillary Services Records
☐ Skin Assessments

☒ Care Guide
☐ Treatment Sheets
☐ Physician Progress Notes
☐ Laboratory and X-ray Reports
☐ Social Service Notes
☐ Meal Intake Records
☐ Weight Records
☒ Assessments
☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☒ Resident/Family Council Minutes
☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☐ Call Light Audits

☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures
☐ Other, specify: ________

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? (•) Yes ( ) No ( ) N/A Specify: ______

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

(•) Yes ( ) No ( ) N/A Specify: ______

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ( ) Yes ( ) No (•) N/A Specify: Facility self-report

If unable to contact complainant, attempts were made on:
Date/time: ____ Date/time: ____ Date/time: ____

Interview with family: ( ) Yes (•) No ( ) N/A Specify: ______

Did you interview the resident(s) identified in allegation: ( ) Yes (•) No ( ) N/A Specify: not interviewable

Did you interview additional residents: ( ) Yes (•) No

Total number of resident interviews: ______

Interview with staff: (•) Yes ( ) No ( ) N/A Specify: ______

Tennessen Warning given as required: (•) Yes ( ) No

Total number of staff interviews: 8

Physician interviewed: ( ) Yes (•) No

Nurse Practitioner interviewed: ( ) Yes (•) No

Interview with Alleged Perpetrator(s): (•) Yes ( ) No ( ) N/A Specify: ______

Attempts to contact: Date/time: ____ Date/time: ____ Date/time: ____

If unable to contact was subpoena issued: ( ) Yes , date subpoena was issued ______ ( ) No

Were contacts made with any of the following:

☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify ______

Observations were conducted related to:

☐ Wound Care ☐ Medication Pass ☒ Meals

☐ Personal Care ☐ Dignity/Privacy Issues ☐ Restorative Care

☐ Nursing Services ☐ Safety Issues ☐ Facility Tour

☐ Infection Control ☐ Cleanliness ☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☐ Other: ________

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: ________

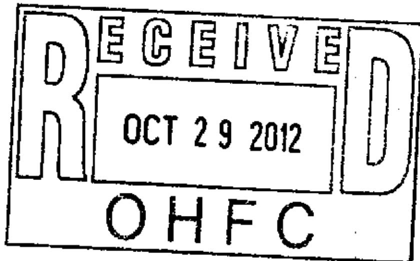
xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Morris City Police Department
Stevens County Attorney
Morris City Attorney

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

PRINTED: 10/16/2012
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 ______ B. WING ______	C 10/02/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted on 08/30/2012 to investigate case #H5262015. As a result, the following deficiency is issued.	F 000		
F 367 SS=G	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the physicians ordered therapeutic diet for 1 of 3 (R1) residents, who were reviewed for receiving a therapeutic diet. This resulted in actual harm for 1 of 1 (R1) resident who choked, and developed aspiration pneumonia, after staff provided food that was not allowed on a mechanical soft diet. Findings include: R1's medical record was reviewed and the physician orders were reviewed and revealed a 7/26/2012 mechanical soft with no hot dogs diet order. R1's care plan in effect on 8/9/2012 revealed a mechanical soft diet with food cut into small pieces with no hot dogs. An internal investigation dated 8/16/2012 revealed staff did not follow R1's care plan of providing R1 with a mechanical soft diet on 8/9/2012. Although R1 had a physicians order for a mechanical soft diet, R1 received a meal, which included a salad with cucumbers. An undated policy titled "Meal Planning for Mechanical Soft	F 367	**OHFC Claim F367 Therapeutic Diet Prescribed by Physician.** **Address how correction action will be accomplished for those residents found to have been affected by the deficient practice?** Beginning on October 19, 2012 when received the 2567, all staff will begin training on the review of diet textures and thickened liquids and the required procedure for food service before serving food meal time or from the Snack cart. Extensive mandatory training on special diets will be conducted for all staff beginning 10-19-12 by the Dietary Manager and/or Registered Dietician.  	

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

10-26-12 Adm

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 ______	C 10/02/2012

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 367 Continued From page 1

Diet" identified raw vegetables, or vegetables with tough skins or membranes as foods to avoid on a mechanical soft diet. R1 required hospitalization after choking on a cucumber. Hospital documentation confirmed paramedics used forceps to remove a large piece of raw cucumber from R1 throat, after multiple Heimlich attempts were unsuccessful. R1 was diagnosed with aspiration pneumonia

A policy dated 02/10 titled "Resident Choice Meal Plan Policy" revealed resident diet cards are to be set at the resident's table place setting for dinner and supper. Staff are to write the resident's meal choice on the dietary card. The resident's dietary card will be brought to the buffet area for the cook to review the diet order, and the resident's choice before serving the food to ensure the correct diet is given to the resident. The diet cards will be at the buffet table for the cooks to review at breakfast.

Nursing assistant/NA (B) was interviewed at 09:38 a.m. on 08/30/2012 and stated NA (B) brought R1's diet card to dietary staff/Employee (C) on 8/9/2012. Employee (C) provided a meal for R1 that included spaghetti, and a salad with cucumbers. NA (B) asked Employee (C) if R1 could eat cucumbers on a mechanical soft diet, and Employee (C) replied affirmatively. NA (B) served R1 the salad with cucumbers.

Employee (C) was interviewed at 2:20 p.m. on 08/30/2012. Employee (C) did not recall NA (B) asking for a mechanical soft diet, or questioning if cucumbers were allowed on a mechanical soft diet. Employee (C) stated cucumbers are not allowed on a mechanical soft diet. Employee (C)

F 367

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

Beginning 10-19-12, the Dietary Manager and Registered Dietician will review all physicians' diet orders to ensure the correct diet is on the resident's diet card.

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

Beginning 10-19-12,West Wind Village will continue to provide diet cards at every meal and snack time for all residents and will educate staff on purpose and importance of using diet cards. The Resident Choice Meal Plan Policy was reviewed and revised on 10/26/12 to include the dietary card will be brought to the buffet area for the cook to review the diet order and resident's choice to ensure the correct diet will be given to the resident for breakfast as well as lunch and supper. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245262	A. BUILDING ______ B. WING ______	C 10/02/2012

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

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F 367 Continued From page 2

went on to say that; staff offers a choice of two meals at lunchtime. Staff frequently requested a meal by verbally indicating number one or number two, not by the resident's diet order. Staff did not always give Employee (C) the resident's diet card when requesting a resident's meal and Employee (C) did not ask for the diet card. Employee (C) did not always verify a resident's diet order prior to providing a resident with a meal that staff requested.

Employee (F)/dietary director was interviewed at 10:51 a.m. on 09/24/2012. Employee (D) stated resident's diet cards are located at the buffet table for breakfast. Dietary staff are expected to verify a resident's diet prior serving the residents. Staff offers the residents two meal choices for lunch and dinner. Dietary or Nursing staff are to write the resident's requests on the resident's diet card, and bring the card to the buffet table. The cook then reviews the card and makes alterations to accommodate the resident's prescribed diet. The cooks are expected to verify the residents' diet on the diet cards, prior to serving a resident. Dietary staff has access to what foods are allowed and what foods should be avoided on a mechanical soft diet. Employee (D) confirmed that cucumbers are not on a mechanical soft diet.

F 367

Diet Texture policy was revised to state that all mechanical soft diets will change to ground meat instead of soft/tender meats.

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.

Audits will be conducted daily for 2 weeks for each meal at each dining location by the Dietary Manager, Director of Nursing, or designee.

Following the listed above 2 weeks, audits will then be done for each meal 5 times a week for 2 weeks by the Dietary Manager, Director of Nursing, or designee.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00654	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 10/02/2012
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) COMPLETE DATE
2 000	Initial Comments	2 000		

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:
A complaint investigation was conducted on 08/30/2012, to investigate complaint #H5262015. No licensing orders are issued.

Following the listed above 2 weeks, audits will then be done for each meal 3 times a week by the Dietary Manager, Director of Nursing, or designee.

Following the listed above 2 weeks, audits will then be done for each meal randomly until the results can be taken to the Quality Assurance Meeting where results will be reviewed and further recommendations will be made by the inter-disciplinary team.

Completion date for the POC will be 11/09/12

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.

Minnesota Department of Health

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 ______	C 10/02/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
West Wind Village
1001 Scotts Avenue
Morris, MN 56267
Stevens County

Report #: H5262015

Date: November 30, 2012

Date of Visit: November 21, 2012
Time of Visit: 7:00 a.m.

By: Lisa Ciesinski, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up one federal deficiency which was issued on October 16, 2012, as the result of an investigation which had been completed on October 2, 2012.

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

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	(Y3) Date of Revisit
245262	A. Building B. Wing	11/21/2012

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 F0367 Reg. # 483.35(e) LSC	Correction Completed 11/09/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/2/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO