

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 05/01/2024
NAME OF PROVIDER OR SUPPLIER West Wind Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Scotts Avenue Morris, MN 56267	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583</p> <p>Based on observation, interview and document review, the facility failed to ensure urinary catheter drainage bags were covered to maintain dignity for 1 of 1 resident (R25) observed with uncovered urinary catheter drainage bag in view of residents, staff and visitors.</p> <p>Findings include:</p> <p>R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had diagnoses of multidrug-resistant organism (bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and renal failure (kidneys are no longer able to filter and clean blood). Identified R25 was severely cognitively impaired and required extensive assistance for bed mobility, transfers, dressing, and personal hygiene. Indicated R25 had an indwelling catheter.</p> <p>R25's care plan last dated 6/13/22, indicated R25 had an indwelling foley catheter due to an open sacral wound that was affected by incontinence and prevented ulcer healing. Identified various interventions which included change catheter per facility policy, position the catheter bag and tubing below the level of the bladder and away from entrance room door, monitor, and keep the catheter bag in a privacy bag when up in wheelchair or in bed.</p> <p>During an observation on 4/29/24 at 3:16 p.m., R25 was laying in bed on her back covered with a blanket and R25's urinary catheter drainage bag was hanging down down on the right side of the bed towards the foot end of the bed. R25's urinary catheter drainage bag was not covered with a privacy bag.</p> <p>During an observation on 4/29/24 at 5:05 p.m., R25 was seated in her wheelchair in the dining room with two other residents. R25's urinary catheter drainage bag was hanging underneath her wheelchair and was not covered with a privacy bag. Urine was observed in the bottom of the catheter bag.</p> <p>During an observation on 4/30/24 at 8:21 a.m., R25 was laying in bed and R25's urinary catheter drainage bag was touching the floor. R25's urinary catheter drainage bag was not covered with a privacy bag, room door was open, and urinary catheter drainage bag was visible from the hallway.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation at 4/30/24 at 11:09 a.m., R25 was seated in her wheelchair in the dining room with the back of her wheelchair facing the doorway to enter the dining room. R25's urinary catheter drainage bag was attached underneath her wheelchair and was not covered with a privacy bag. R25's urinary catheter drainage bag had visible urine in the bottom of the bag.</p> <p>During an interview on 4/30/24 at 3:45 p.m., family member (FM) indicated R25 had an indwelling foley catheter and it would bother R25 to have the urinary catheter drainage bag exposed so other people could see it. FM stated R25 would be embarrassed without the privacy bag covering the urinary catheter drainage bag .</p> <p>During an interview on 5/01/24 at 12:53 p.m., nursing assistant (NA)-C indicated R25 had a foley catheter and required assistance with personal hygiene. NA-C stated a privacy bag should have been placed over the urinary catheter drainage bag when attached under her wheelchair and when R25 was laying in bed.</p> <p>During an interview on 5/01/24 at 1:45 p.m., licensed practical nurse (LPN)-A revealed R25 had a foley catheter placed to help reduce the amount of moisture around the sacral area to help heal the ulcer. LPN-A stated R25 should have had a privacy bag covering her urinary catheter drainage bag when up in her wheelchair or laying in bed. LPN-A's expectations were all urinary catheter drainage bag were covered with a privacy bag.</p> <p>During an interview on 5/01/24 at 3:24 p.m., director of nursing (DON) confirmed the above findings and indicated all urinary catheter drainage bag needed to be covered and staff were expected to place the privacy bag over a urinary catheter drainage bag at all times.</p> <p>Review of the facility policy titled Catheter Care issued 9/11/23, catheter care would be completed to maintain catheter patency, prevent infection, and ensure dignity. Cover drainage bag with a cloth/vinyl bag to protect the dignity of the resident.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on interview and document review, the facility failed to ensure procedures were implemented and followed to ensure sufficient medication supplies, timely medication re-ordering, after hours on-call pharmacy use, and appropriate action(s) taken when a medication was not available for administration for 1 of 3 residents (R147) reviewed for medication administration.</p> <p>Findings include:</p> <p>A Vulnerable adult maltreatment report was submitted to the State Agency (SA) on 9/18/23 at 12:55 p.m., and identified R147's ordered Oxycodone (pain medication) was out of supply; thus, R147's Oxycodone was omitted on the morning of 9/18/23 and R147 was sent to the emergency room for out of control cancer pain In addition, the report indicated his medical record lacked evidence staff followed-up with the pharmacy or that his provider was notified timely.</p> <p>R147's significant change Minimum Data Set (MDS), dated [DATE], identified R147 was severely cognitively impaired with diagnoses of cancer, diabetes, arthritis and anxiety. Indicated R147 received scheduled pain medication daily.</p> <p>R147's care plan/service plan identified R147 experienced an alteration in pain related to prostate cancer, osteoarthritis. The care plan directed medication was to be administered as ordered.</p> <p>A nurses note on point click care (PCC) from the facility on 9/18/23, from LPN-B indicated R147's Oxycodone was ordered from pharmacy on 9/15/23, however was not delivered; thus R147 did not receive his Oxycodone the morning of 9/18/23. R147 was hollering out in pain. Every touch and movement R147 was screaming out in pain.</p> <p>R147's September 2023 medication administration record (MAR) directed staff to administer R147 Oxycodone 10mg (milligrams) in the morning related to pain. The MAR identified on 9/18/23, a recorded entry of DNA (drug not available).</p> <p>R147's medical record lacked evidence staff followed-up with pharmacy on the lack of Oxycodone supply, or contacted/updated R147's provider.</p> <p>During an interview on 5/1/24 at 9:01 a.m., licensed practical nurse (LPN-B) confirmed R147 went to the emergency roiaognom on [DATE] related to uncontrolled pain. LPN-B stated she did not recall why his pain medication was not refilled as it was ordered the Friday before. LPN-B verified she was unaware of medications available in the emergency kit or the policy on how and when to use the emergency kit.</p> <p>During an interview on 5/1/24 at 9:22 a.m., registered nurse (RN)-A stated she did not recall why R147 went to the emergency roiaognom on [DATE]. RN-A stated she recalled R147 was admitted to the facility with cancer diagnosis, was to receive therapy and was hopeful to return home. RN-A was unable to provide a process for when the emergency kit would be utilized or a process to update the doctor when a resident's medications were unavailable.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/24 at 9:32 a.m., LPN-A verified medications were reordered from the pharmacy when there were eight to nine pills left for a resident. LPN-A stated she would alert the charge nurse and the pharmacy if a medication was not delivered to the facility when needed for a resident. LPN-A stated the facility had a standing order for Tylenol otherwise there were no other pain medications available for a resident if needed. LPN-A confirmed she was unaware of what medications were in the emergency kit or the policy on how and when to use the emergency kit.</p> <p>During an interview on 5/1/24 at 9:40 a.m., RN-B stated the facility would call the pharmacy first if unable to manage a resident's pain and then would sent to the emergency room . RN-B did not indicate the doctor would be updated if a resident was out of pain medications and had pain and verified the facility had an emergency medication kit however was unaware of what medications were in the kit.</p> <p>During an interview on 5/1/24 at 12:12 p.m., emergency room doctor verified the expectation that the facility would contact the on call provider to obtain a refill of a pain medication prior to sending a resident to the emergency room .</p> <p>On 5/1/24 at 10:05 a.m., a message was left for the facility's medical director with no return call received.</p> <p>During an interview on 5/1/24 at 9:46 a.m., the director of nursing (DON) stated her expectation was nurses would update the doctor if a resident was having pain and request pain medications. DON stated the facility had a standing order for Tylenol however no other pain medications were available in the facility for emergency use. DON confirmed the facility has an emergency medication kit however was unaware of what medications were in the emergency kit or when the kit would be utilized. DON stated she was unaware of the process and training for the nurses on the use of the emergency kit and that the facility rarely used the emergency kit as the pharmacy was available seven days a week and the facility was able to obtain medications when needed.</p> <p>During an interview on 4/30/24 at 3:13 p.m., the consulting pharmacist stated the expectation was that the facility would alert the provider if they were out of a medication and that the facility would have a policy on how to use the emergency kit.</p> <p>During an interview on 4/30/24 at 3:26 p.m., the pharmacist from Thrifty [NAME] stated the expectation was the facility would alert the provider when they were out of a medication. The pharmacist stated the pharmacy delivered medications to the facility seven days a week when necessary. When a medication was needed after those hours, she expected the facility staff to utilize their emergency kit and contact the on call doctor.</p> <p>During an interview on 4/30/24 at 2:45 p.m., R147's family member denied concerns with R147's stay; however she was concerned that family was not contacted about R147 having uncontrolled pain and that R147 was sent to the emergency room .</p> <p>During an interview on 4/30/24 at 11:17 a.m., the complainant verified the vulnerable adult report information when reviewed and that R147 came to the emergency room related to uncontrolled pain. He stated the notes sent from the facility stated that R147 was out of pain medication and he did not understand why R147 was sent to the emergency room instead of the facility contacting the doctor for pain medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nine month review of pharmacy reorder forms were requested and not provided. Two pharmacy binders were received for review; Thrifty [NAME] pharmacy dated from 2/15/24 through 4/28/24 and the other pharmacy binder from [NAME] Drug lacked any documentation from 9/18/23.</p> <p>A Medication Administration policy, dated 8/7/23, lacked documentation on a procedure if a resident did not have a medication available as ordered. The policy lacked direction(s) related to the pharmacy reordering and/or adequate med supply processes, processes for staff to follow when a med was unfound, and/or the processes for on-call pharmacy utilization.</p> <p>An Emergency Kit policy, undated, stated if the facility had an order for a medication but were out of the resident's medication to follow steps three through five on the emergency kit policy: Write the order in the charge book, write the medication taken in black e-kit binder and take the medication from the e-kit for the resident use.</p> <p>Review of all nurse staff education lacked specific training on use of the emergency kit process and procedures.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583</p> <p>Based on interview and document review, the facility failed to submit complete and accurate direct care staffing information based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 1), to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. This deficient practice had the potential to affect all 47 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the Payroll Based Journal Report (PBJ) [NAME] Report 1705D identified the following dates triggered for review: 10/21/23, 11/11/23, 11/19/23, 11/25/23, 12/2/23, 12/10/23, 12/30/23, and 12/31/23 for failure to have licensed nurse coverage 24 hours per day.</p> <p>Review of staffing schedules from 10/15/23 through 12/31/23, identified the facility had 14 staff identified to have worked: registered nurse (RN)-C, RN-D, RN-E, RN-F, RN-G, licensed practical nurse (LPN)-A, LPN-B, LPN-C, LPN-D, LPN-E, LPN-F, LPN-G, LPN-H, and LPN-I on each of the above dates listed.</p> <p>In addition, review of staff's time cards on the above-mentioned dates identified licensed nursing staff had worked.</p> <p>Review of the facility's staffing schedules and time cards identified a discrepancy with the PBJ report.</p> <p>During an interview on 5/01/24 at 3:20 p.m. director of nursing (DON) and registered nurse quality consultant (RNQC) verified the above findings and indicated St. [NAME] Health Services, Inc. (SFHS) entered the PBJ reports and they had not been entered correctly.</p> <p>Review of facility policy titled Payroll Based Journal reviewed/amended 4/1/19, SFHS would gather, submit and utilize Payroll Based Journal information as required by regulation. SFHS's Employment System Department (ESD) will review all PBJ data for accuracy and submit prior to the CMS mandated deadline (45 days after quarter end).</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</p> <p>Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 2 of 3 residents (R7, R29) observed for enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to implement the water management plan for the prevention of Legionella (a bacterium) in the facility water system. This deficient practice had the potential to affect all 47 residents who resided in the facility. Further, the facility failed to ensure water pitchers were delivered in a manner that prevented risk of contamination for 2 of 3 hallways observed for water pitcher pass. In addition, the facility failed to ensure catheter drainage bags and wound vacs were properly placed to prevent the risk for cross contamination for 1 of 1 residents (R25) reviewed for catheter care.</p> <p>Findings include:</p> <p>ENHANCED BARRIER PRECAUTIONS, PPE USE AND HAND HYGIENE</p> <p>Review of CDC guidance dated [DATE], Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>R29</p> <p>R29's quarterly Minimum Data Set (MDS) dated [DATE], identified R29 had moderate cognitive impairment and diagnoses which included dementia, depression, and diabetes mellitus (DM). Identified R29 required moderate assistance for activities of daily living (ADL's) which included toileting, transfers, and dressing.</p> <p>R29's care plan dated [DATE], indicated R29 indicated R29 required staff assistance to toilet. Care plan indicated R29 was occasionally incontinent of bladder.</p> <p>R29's electronic health record (EMR) banner identified R29 was colonized (being a carrier but not actively infected) with Methicillin - resistant Staphylococcus aureus (MRSA) (an infection caused by a type of staph bacteria that's become resistant to many antibiotics).</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 12:06 p.m., a plastic storage bin was present on the floor outside of R29's room which contained gowns, gloves and masks. A sign was on R29's door sign that identified Enhanced Barrier Precautions; Everyone Must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer a gown and gloves.</p> <p>During an observation on [DATE] at 1:23 p.m., nursing assistant (NA)-A entered R29's room with a standing lift. NA-A had no PPE on, including gloves and gown. NA-A stood within an inch of R29 and proceeded to place a sling around R29, used the standing lift to lift R29 into the air, pulled down R29's pants and placed R29 on the toilet. After toileting, NA-A operated the standing lift to lift R29 into the air, pulled up R29's pants, placed R29 into her wheelchair and brought the standing lift into the hallway. NA-A did not perform hand hygiene at any time during the observation.</p> <p>During an interview on [DATE] at 1:32., NA-A verified he had not worn any PPE while transferring R29 to the bathroom or performed hand hygiene. NA-A stated he should have worn a gown and gloves while assisting R29 to use the bathroom. NA-A indicated he should have performed hand hygiene before and after providing direct care to R29.</p> <p>R7</p> <p>R7's quarterly MDS dated [DATE], identified R7 had intact cognition and diagnoses which included renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), traumatic brain injury and diabetes mellitus (DM). Identified R7 required limited assistance for (ADL's) which included toileting, transfers, and dressing.</p> <p>R7's care plan dated [DATE], indicated R9 indicated R7 required staff assistance to toilet. Care plan indicated R7 was occasionally incontinent of bowel and bladder.</p> <p>R7's EMR banner identified R7 was colonized with MRSA.</p> <p>During an observation on [DATE] at 1:26 p.m., a plastic storage bin was located outside of R7's room which contained gowns, gloves and masks. A sign was noted on R7's door sign that identified Enhanced Barrier Precautions; Everyone Must clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high contact resident activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. In addition, the sign contained a picture of hand sanitizer, gown and gloves.</p> <p>During an interview on [DATE] at 1:28 p.m., R7 stated he was unsure why there was a sign on his door and PPE out in the hall because staff did not use any PPE when they provided care for him.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 2:00 p.m., NA-B entered R7's room and informed R7 she was going to change R7's incontinent product for him. NA-B sanitized hands, applied gloves and did not apply any other PPE. NA-B stood within one inch of R7, asked R7 to stand up and NA-B proceeded to remove R7's soiled brief. NA-B placed the soiled brief into a bag, wiped R7's bottom with a wipe, removed her gloves and placed a clean brief on R7. NA-B walked out of the room, placed the soiled brief in the utility room and sanitized her hands.</p> <p>During an interview on [DATE] at 2:07 p.m., NA-B verified she had not worn a gown while providing incontinent cares for R7. NA-B stated she should have been wearing a gown and gloves while providing incontinent cares for R7.</p> <p>During an interview on [DATE] at 9:18 a.m., infection preventionist (IP) confirmed R7 and R29 were on enhanced barrier precautions for colonization of MRSA. IP stated her expectation was staff would have worn PPE and performed hand hygiene when indicated when caring for residents on EBP. IP indicated staff had been educated on EBP and that she would provide further education to the staff.</p> <p>During an interview on [DATE] at 11:59 a.m., director of nursing (DON) verified R7 and R29 were on enhanced barrier precautions for colonization of MRSA. DON stated her expectation was for staff to perform hand hygiene and wear the correct PPE when caring for residents on enhanced barrier precautions.</p> <p>48583</p> <p>WATER MANAGEMENT PROGRAM</p> <p>During an observation on [DATE] at 3:26 p.m., standing water was present in the indoor river located in the middle of the sitting area. The standing water was approximately two to three feet deep nearest rooms , d+[DATE]. The water in the river continued to become more shallow moving down the river towards rooms , d+[DATE]. The approximate length of the river was 38 feet long from end to end. [NAME] residue in a line pattern was noted on the inside of the downward flowing rock bed into river. [NAME] residue approximately one inch wide circled the entire perimeter of the rock bed into the river and was present on all edges. Nearest rooms ,d+[DATE], white residue was approximately three to four inches above the water level and approximately one inch wide. Reflective shiny blue/green/purple film swirled throughout the entire standing water in the river from end to end.</p> <p>During an observation on [DATE] at 7:45 p.m., a two feet by one and a half foot section of the river contained a translucent film noted on the top of the water near the end river by the bridge. One fish noted to be moving in the deepest part of the creek nearest rooms ,d+[DATE]. [NAME] slimy substance was noted on the bottom of the river covering the entire bed of the river where the water was standing. A hose was attached to a water spigot on the wall near the top of the river. The hose was coiled up and the end was placed down into a wire grate. No water was running at the time.</p> <p>During an observation on [DATE] at 10:20 a.m., the river continued to be the same as above.</p> <p>During an observation on [DATE] at 11:36 a.m., the river continued to be the same as above.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 10:20 a.m., during resident council, residents indicated the river had not been running for more than a year. Residents stated there used to be fish in the river however they had all died .</p> <p>During an interview on [DATE] at 9:12 a.m., maintenance director (MD) confirmed the above findings and indicated the river was shut down due to a leak and water was added to the river every week and flushed down the drain. MD stated all that was done as part of the water management plan was to add water to the river. MD stated I flush all the slime and stuff out and let it run down the drain until the river is clear again. MD indicated that water was added weekly not daily as written on the Legionella checklist. MD confirmed there was green slim covering the entire rock bed and revealed the river bed had not been cleaned since it stopped working. MD was unsure what the film on the top of the water was. MD indicated, It grows so quickly. I can already see it coming back from yesterday's flush. I am not sure why it continues to grow or how to get rid of it. MD verified there were two sucker fish (bottom feeders) in the river and they fed off of the bottom of the river and stated they feed off the bottom of the river. MD stated he was aware corporate was working on the river issue however was unsure what corporate's plan was to resolve the water management issue.</p> <p>During a follow- interview on [DATE] at 9:51 a.m., MD indicated the river stopped working in the first part of [DATE] and had not ran since then.</p> <p>CATHETER DRAINAGE BAG/ WOUND VAC</p> <p>During an observation on [DATE] at 3:16 p.m., R25 was laying in bed on her back covered with a blanket and R25's urinary catheter drainage bag was hanging down on the right side of the bed towards the foot end of the bed touching the floor. R25's wound vac was located on the floor near the head of the bed.</p> <p>During an observation on [DATE] at 8:21 a.m., R25 was laying in bed and R25's urinary catheter drainage bag was touching the floor. R25's wound vac was located on the floor near the head of the bed.</p> <p>During an interview on [DATE] at 12:53 p.m., nursing assistant (NA)-C indicated R25 had a foley catheter and required assistance with personal hygiene. NA-C stated the foley catheter bag should not have been touching the floor. NA-C indicated R25's wound vac should have been stationed on her wheelchair or bedside table and off the floor.</p> <p>During an interview on [DATE] at 1:45 p.m., licensed practical nurse (LPN)-A revealed R25 had a foley catheter placed to help reduce the amount of moisture around the sacral area to help heal the ulcer. LPN-A stated R25's urinary catheter drainage should not have been touching the floor.</p> <p>49620</p> <p>HAND HYGIENE DURING WATER PITCHER PASS</p> <p>(continued on next page)</p>		

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 05/01/2024
NAME OF PROVIDER OR SUPPLIER West Wind Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Scotts Avenue Morris, MN 56267	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 11:01 a.m., dietary aide (DA)-A with developmental achievement center (DAC) job coach pushed a cart down hall with approximately 30 water jugs all with straws uncovered on top shelf of cart going past visitors. DA-A knocked on R24's door, delivered new water jug to R24's room, DA-A exited room with used water jug and placed on bottom shelf of cart. Job coach knocked on R12's door, delivered new water jug to R12's room, job coach exited room with used water jug and placed on bottom shelf of cart. DA-A delivered new water jug to R21 room, DA-A exited room with used water jug and placed on bottom shelf of cart. DA-A knocked on R28's door, delivered new water jug to R28's room, DA-A exited room with used water jug and placed on bottom shelf of cart. Job coach knocked on R200's door, delivered new water jug to R200's room, job coach exited room with used water jug and placed on bottom shelf of cart. DA-A delivered new water jug to R41's room, DA-A exited room with used water jug and placed on bottom shelf of cart. DA-A knocked on R38's door, delivered new water jug to R38's room, DA-A exited room with used water jug and placed on bottom shelf of cart. Job coach knocked on R202's door, delivered new water jug to R202 room, job coach exited room with used water jug and placed on bottom shelf of cart. DA-A knocked on R15's door, delivered new water jug to R15's room, DA-A exited room with used water jug and placed on bottom shelf of cart. DA-A knocked on R23's door, delivered new water jug to R23's room, DA-A exited room with used water jug and placed on bottom shelf of cart. Job coach delivered new water jug to R9's room, job coach exited room with used water jug and placed on bottom shelf of cart. Job coach knocked on R14's door, delivered new water jug to R14's room, job coach exited room with used water jug and placed on bottom shelf of cart. Job coach removed straw from R14's used water jug and threw straw into garbage on dirty dish cart by dining room. DA-A pushed the cart down the hall past visitors and delivered new water jug to R40's room, DA-A exited room with used water jug and placed on bottom shelf of cart. Job coach knocked on R11's door, delivered new water jug to R11's room, job coach exited room with used water jug and placed on bottom shelf of cart.</p> <p>DA-A did not sanitize hands during the entire water pass observation.</p> <p>Job coach did not sanitize hands during the entire water pass observation.</p> <p>During an interview on [DATE] at 12:01 p.m., job coach stated there had not been paper covers on the straws for sometime and was unsure how long. Job coach verified both the DA-A and herself did not sanitize hands between touching clean and dirty water jugs between resident rooms. Job coach stated she had not received any training on infection control practices from the facility and did not see a concern with not sanitizing hands between touching clean and dirty water jugs between resident rooms.</p> <p>During an interview on [DATE] at 2:46 p.m., dietary manager verified the facility trained a job coach from DAC years ago with the expectation that person would train other job coaches. Dietary manager stated she was unaware the straws did not have paper covers on them. Dietary manager indicated the expectation was staff would sanitize hands in between resident rooms when removing dirty water jugs prior to delivering new water jugs to prevent illness from one resident to another.</p> <p>During an interview on [DATE] at 9:18 a.m., infection preventionist (IP) confirmed R7 and R29 were on enhanced barrier precautions for colonization of MRSA. IP stated her expectation was staff would have worn PPE and performed hand hygiene when indicated when caring for residents on EBP. IP indicated staff had been educated on EBP and that she would provide further education to the staff.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 11:59 a.m., director of nursing (DON) verified R7 and R29 were on enhanced barrier precautions for colonization of MRSA. DON stated her expectation was for staff to perform hand hygiene and wear the correct PPE when caring for residents on enhanced barrier precautions.</p> <p>During an interview on [DATE] at 2:49 p.m., infection preventionist (IP) confirmed the above findings and stated the river has spores or something. The river has been an issue and we have been trying to get it taken out but it has been elevated to a corporate level. I do see a concern with it but I can't do anything with it. At a corporate level it has stalled at this point.</p> <p>During an interview on [DATE] at 2:05 p.m., with director of nursing (DON), a policy on pets was requested. DON stated there was not any fish in the river. Explained MD indicated there were two fish, bottom feeders, that were still living in the river. DON was unaware there were fish still living in the river.</p> <p>During a follow-up interview on [DATE] at 3:29 p.m., DON confirmed the above findings and revealed the river was not running and water remained in the river. DON indicated maintenance was responsible for taking care of the river. DON stated she was aware water was added however was not aware anything else was being done as part of the water management plan for the river. DON said corporate was aware of the river issue and they were working on it.</p> <p>During an interview on [DATE] at 3:24 p.m., director of nursing (DON) and registered nurse quality consultant (RNQC) confirmed the above findings and indicated all urinary catheter drainage bag needed to be off the floor at all times. RNQC indicated if bed was in a low position, urinary catheter drainage bags should have been placed in a wash basin to prevent them from laying directly on the floor to prevent cross contamination.</p> <p>During an interview on [DATE] at 3:25 p.m., IP stated she was unaware straws did not have paper covers on them. IP confirmed straws should have covers and verified her expectation was staff would sanitize hands in between touching dirty and clean water jugs to prevent the spread of infection. IP was unaware of any training that DAC staff had received.</p> <p>During an interview on [DATE] at 3:36 p.m., director of nursing (DON) confirmed the DAC staff had not received any training for infection prevention.</p> <p>A facility policy titled Enhanced Barrier Precaution dated [DATE], identified the facility would apply Enhanced Barrier Precautions to prevent the spread of Multi- Drug Resistant Organisms (MDRO's). identified EBP should have been used when providing high contact care to residents who were colonized or infected with an MDRO when contact or other precautions did not apply. Identified EBP which included wearing a gown and gloves were employed when performing the following high contact resident care activities: Dressing, Bathing, Changing Linen, Transferring, Hygiene care, Toileting, Peri care, Emptying Catheter bags, Wound Care, Indwelling medical devise care, Therapy treatments.</p> <p>A facility policy titles Hand Hygiene revised [DATE], identified staff were to routinely perform hand hygiene to prevent and control the spread of infection. Identified staff were to perform hand hygiene before and after direct contact with a resident.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Water Management Program (WMP) Reduce Growth and Spread of Legionella Checklist dated [DATE] to [DATE], revealed the chapel sink was flushed weekly. Review of the river (wells river) indicated reverse osmosis system adds water daily however lacked documentation water was being added.</p> <p>Review of Water Management Program Legionella Prevention reviewed/amended [DATE], indicated the WMP would identify specific potential hazard areas where Legionella could grow and spread. Water features: Fountains, ponds, and [NAME] within the care center would be inspected for biofilm (green slime) buildup on the rocks and the bottom of the water features. This would indicate cleaning of the water feature was needed.</p> <p>Requested a policy on pet fish, however one was not received.</p> <p>Review of the facility policy titled Catheter Care issued [DATE], make sure catheter tubing and drainage bags were kept off the floor. Place in a basin if it could not hang from the bed.</p> <p>Review of the facility policy titled Wound Vac Dressing change undated, did not indicate any information about where the wound vac should be placed at all times.</p> <p>A facility policy titled Fresh Water Pass revised ,d+[DATE], stated the top of a straw would be covered with a wrap. Hands would be cleansed with hand sanitizer before next clean mug/glass was delivered into the next residents room.</p>		