Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 5, 2024

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

RE: CCN: 245262
Cycle Start Date: May 1, 2024

Dear Administrator:

On May 31, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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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 05/01/2024

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

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E 000	Initial Comments On 4/29/24 to 5/1/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/29/24 to 5/1/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed. The following complaint was reviewed with no deficiency issued. H52623422C (MN00102784). AND The following complaint was reviewed. H52623354C (MN00097034) with a deficiency issued at (F755). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/17/2024

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 000	Continued From page 1 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		5/27/24

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F 550	Continued From page 2 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: 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. Findings include: R25's quarterly Minimum Data Set (MDS) dated 3/26/24, 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. R25's care plan last dated 6/13/22, indicated R25	F 550	R25's catheter bag was placed in a catheter bag, covered to maintain the dignity of the resident. Catheter Care Policy & Procedure was reviewed. Nursing staff will be trained on the Catheter Care Policy. All residents with catheters will be audited to ensure their catheter bag is covered. Catheter bags will be audited to ensure they are always covered. Audits will be completed 2x/week for 4 weeks, then weekly for 4 weeks then monthly. Results will be brought back to QAPI for further recommendations. DON or designee is responsible for compliance.	

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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.

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.

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.

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.

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

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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.

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 .

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.

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.

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.

Review of the facility policy titled Catheter Care

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F 550	Continued From page 5 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.	F 550		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		5/27/24

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F 755	Continued From page 6 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: 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. Findings include: 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. R147's significant change Minimum Data Set (MDS), dated 10/3/23, identified R147 was severely cognitively impaired with diagnoses of cancer, diabetes, arthritis and anxiety. Indicated R147 received scheduled pain medication daily. 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. A nurses note on point click care (PCC) from the	F 755	Medication Administration Policy and Procedure was reviewed and revised to include procedure for medication supply. Pharmacy Emergency Kit Policy and Procedure was reviewed and revised. All licensed nurses will be trained on the Pharmacy Services P&P and on the Emergency Kit P&P. All residents will be audited to ensure sufficient medical supplies, timely medication re-ordering, after hours on-call pharmacy use and appropriate action taken when a medication is not available for administration. Audits will be completed 2x/week for 4 weeks, then weekly for 4 weeks then monthly. Results will be brought back to QAPI for further recommendations. DON or designee is responsible for compliance.	

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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.

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).

R147's medical record lacked evidence staff followed-up with pharmacy on the lack of Oxycodone supply, or contacted/updated R147's provider.

During an interview on 5/1/24 at 9:01 a.m., licensed practical nurse (LPN-B) confirmed R147 went to the emergency room on 9/18/23 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.

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 room on 9/18/23. 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

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medications were unavailable.

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.

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.

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.

On 5/1/24 at 10:05 a.m., a message was left for the facility's medical director with no return call received.

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

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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.

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.

During an interview on 4/30/24 at 3:26 p.m., the pharmacist from Thrifty White Morris 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.

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.

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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.

A nine month review of pharmacy reorder forms were requested and not provided. Two pharmacy binders were received for review; Thrifty White pharmacy dated from 2/15/24 through 4/28/24 and the other pharmacy binder from Seip Drug lacked any documentation from 9/18/23.

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.

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.

Review of all nurse staff education lacked specific training on use of the emergency kit process and procedures.

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F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5)	F 851		5/27/24

§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.
Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each

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F 851	Continued From page 12 category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: 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. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705D identified the following dates triggered for review: 10/21/23, 11/11/23,	F 851	West Wind Village's intent is to ensure all staffing hours are submitted and accurate to MDH/CMS through PBJ. Individuals that submit PBJ have been educated as of 05/02/2024 on the correct and accurate submissions of PBJ to MDH/CMS. WWV will work in conjunction with our employment systems associates to ensure compliant practices are occurring and accurate reports are being submitted through CMS. Administrator will audit PBJ hours prior to submission each quarter. Audits will be reviewed at QAPI to provide further direction or additional auditing.	

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F 851	Continued From page 13 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. Review of staffing schedules from 10/15/23 thorough 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. In addition, review of staff's time cards on the above-mentioned dates identified licensed nursing staff had worked. Review of the facility's staffing schedules and time cards identified a discrepancy with the PBJ report. 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. Francis Health Services, Inc. (SFHS) entered the PBJ reports and they had not been entered correctly. 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).	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/27/24

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F 880	Continued From page 14 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 15 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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	F 880	Enhanced Barrier Precautions Policy and Procedure was reviewed. Hand Hygiene Policy and Procedure was reviewed. Catheter Care Policy and Procedure was reviewed. Wound Vac Dressing Change Policy was reviewed and revised. R 25s catheter bag was placed in a basin to keep it off the floor. R 25s wound vac was placed on the bedside stand, to keep it off the floor.	

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F 880	Continued From page 16 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. Findings include: ENHANCED BARRIER PRECAUTIONS, PPE USE AND HAND HYGIENE Review of CDC guidance dated 4/1/24, 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. R29 R29's quarterly Minimum Data Set (MDS) dated 2/13/24, identified R29 had moderate cognitive impairment and diagnoses which included dementia, depression, and diabetes mellitus	F 880	All nursing staff will be trained on the EBP Policy, Hand Hygiene Policy, Wound Vac Dressing Change Policy, and the Catheter Care Policy. Audits will be completed to ensure appropriate hand hygiene is performed before and after providing direct resident care and donning/doffing of PPE is performed in residents observed for EBP. Audits will be completed to ensure catheter bags and the Wound VAC are not on the floor. Audits will be performed 2x/week for 4 weeks, then weekly for 4 weeks then monthly. Results will be brought back to QAPI for further recommendations. DON or designee is responsible for compliance. Environmental Services and or Designee will remove the fish from the pond. Environmental Services and/or designee will work with the Environmental Services Director to drain the river and then clean it to remove the film around the rocks. There will be no knew water added to the river. Environmental Services and/or Designee will then monitor on weekly rounds to determine if there is any new growth that needs to be removed. Environmental Services and / or designee will complete audits weekly x4 and monthly X 1. Environmental Services and/or designee will bring audits to the Quality assurance Committee quarterly X1. The Dietary Manager and/or Designee will	

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(DM). Identified R29 required moderate assistance for activities of daily living (ADL's) which included toileting, transfers, and dressing.

R29's care plan dated 10/18/23, indicated R29 indicated R29 required staff assistance to toilet. Care plan indicated R29 was occasionally incontinent of bladder.

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).

During an observation on 4/29/24 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.

During an observation on 4/29/24 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

Provider's plan of correction:

make sure all of the unwrapped straws are discarded and made unavailable for any resident use.
The Dietary Manager and / or designee will make sure all Cupboards will be stocked with wrapped straws.
The Dietary Manager and/ or Designee will educate dietary staff on the current hand hygiene and water pass policies will be completed with the DAC job coaches and staff.
Dietary Manager and/or Designee will complete audits weekly X 4 and Monthly X 3.
The Dietary Manager and/or Designee will bring audits to the QAPI committee monthly x 3 and quarterly X 1 for further recommendations.

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F 880	Continued From page 18 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. During an interview on 4/29/24 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. R7 R7's quarterly MDS dated 2/14/24, 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. R7's care plan dated 6/1/23, indicated R9 indicated R7 required staff assistance to toilet. Care plan indicated R7 was occasionally incontinent of bowel and bladder. R7's EMR banner identified R7 was colonized with MRSA. During an observation on 4/29/24 at 1:26 p.m., a plastic storage bin was located outside of R7's room which contained gowns, gloves and masks.	F 880		

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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.

During an interview on 4/29/24 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.

During an observation on 4/29/24 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.

During an interview on 4/29/24 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.

During an interview on 5/1/24 at 9:18 a.m.,

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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.

During an interview on 5/1/24 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.

WATER MANAGEMENT PROGRAM

During an observation on 4/29/24 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 206/207. The water in the river continued to become more shallow moving down the river towards rooms 220/221. The approximate length of the river was 38 feet long from end to end. White residue in a line pattern was noted on the inside of the downward flowing rock bed into river. White residue approximately one inch wide circled the entire perimeter of the rock bed into the river and was present on all edges. Nearest rooms 206/207, 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.

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During an observation on 4/29/24 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 206/207. Green 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.

During an observation on 4/30/24 at 10:20 a.m., the river continued to be the same as above.

During an observation on 4/30/24 at 11:36 a.m., the river continued to be the same as above.

During an interview on 4/30/24 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.

During an interview on 5/1/24 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

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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.

During a follow- interview on 5/1/24 at 9:51 a.m., MD indicated the river stopped working in the "first part of January 2023" and had not ran since then.

CATHETER DRAINAGE BAG/ WOUND VAC

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 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.

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 wound vac was located on the floor near the head of the bed.

During an interview on 5/1/24 at 12:53 p.m., nursing assistant (NA)-C indicated R25 had a foley catheter and required assistance with personal hygiene. NA-C stated the foley catheter

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F 880	Continued From page 23 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. During an interview on 5/1/24 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's urinary catheter drainage should not have been touching the floor. HAND HYGIENE DURING WATER PITCHER PASS During an observation on 4/30/24 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	F 880		

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F 880	Continued From page 24 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.	F 880		

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	245262	A. BUILDING ____ B. WING ____	C 05/01/2024

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 880	Continued From page 25 DA-A did not sanitize hands during the entire water pass observation. Job coach did not sanitize hands during the entire water pass observation. During an interview on 4/30/24 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. During an interview on 5/1/24 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. During an interview on 5/1/24 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.	F 880		

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F 880	Continued From page 26 During an interview on 5/1/24 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. During an interview on 5/1/24 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". During an interview on 5/1/24 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. During a follow-up interview on 5/1/24 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. During an interview on 5/1/24 at 3:24 p.m., director of nursing (DON) and registered nurse quality consultant (RNQC) confirmed the above	F 880		

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F 880	Continued From page 27	F 880		

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.

During an interview on 5/1/24 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.

During an interview on 5/1/24 at 3:36 p.m., director of nursing (DON) confirmed the DAC staff had not received any training for infection prevention.

A facility policy titled Enhanced Barrier Precaution dated 3/25/24, 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.

A facility policy titles Hand Hygiene revised

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F 880	Continued From page 28	F 880		

5/8/17, 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.

Review of Water Management Program (WMP) Reduce Growth and Spread of Legionella Checklist dated 11/28/22 to 4/23/24, 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.

Review of Water Management Program Legionella Prevention reviewed/amended 2/24/24, indicated the WMP would identify specific potential hazard areas where Legionella could grow and spread. Water features: Fountains, ponds, and rivers 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.

Requested a policy on pet fish, however one was not received.

Review of the facility policy titled Catheter Care issued 9/11/23, make sure catheter tubing and drainage bags were kept off the floor. Place in a basin if it could not hang from the bed.

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.

A facility policy titled Fresh Water Pass revised

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F 880	Continued From page 29 12/23, 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.	F 880		

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	245262	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/02/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/02/2024. At the time of this survey, West Wind Village was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Health Care Facilities Code (NFPA 99). 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/17/2024

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 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The West Wind Village was constructed at four different times. The original building was built in 1962, is 1-story, with a basement, and was determined to be of a Type V (111) construction	K 000		

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K 000	Continued From page 2 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 the 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; it 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. West Wing Pod addition 02 of West Wind Village Care Center consists of a 2015 building addition and is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (000) construction. The facility is fully fire sprinkler protected and also has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 72 beds and the census was 47 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K 324		5/27/24

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K 324	Continued From page 3 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/02/2024 between 9:15 and 11:30 AM, it was revealed by observation that a stove in the Therapy Area did not have a timer, not exceeding 120	K 324	Environmental services contacted a local vendor to install a timer on the stove. Environmental services will check for any other appliances that need a timer. Environmental Services and/or Administrator will Educate all Therapy staff that use the stove on the Timer and NFPA 101. Environmental Services and/or designee will complete audits weekly x2 and monthly x3. Environmental Services and/ or designee	

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K 324	Continued From page 4 minutes, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 324	will bring audits to the Quality Assurance committee for review monthly x1 and Quarterly X 1.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ____ b) Who provided system test ____ c) Water system supply source ____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.2, and 5.2.2.2. These deficient findings could have an isolated impact on	K 353	Environmental Services removed the storage container on the top of the shelf of the Activities storage closet that was too close to the sprinkler head in accordance with NFPA 101. Environmental Services checked all closets in Therapy for containers or items too close to the sprinkler heads in	5/27/24

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K 353	Continued From page 5 the residents within the facility. Findings include: 1. On 05/02/2024 between 9:15 and 11:30 AM, it was revealed by observation that a storage container on the top shelf of the Activities storage closet was too close to the sprinkler head. Violation was corrected at the time of discovery. 2. On 05/02/2024 between 9:15 and 11:30 AM, it was revealed by observation that there were wires and conduit in contact with, and resting on top of the sprinkler pipe above the suspended ceiling near room 143. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 353	accordance with NFPA 101. Environmental Services and/or designee will check all other closets in the building in accordance with NFPA 101. Environmental Services and/or Designee will educate staff on NFPA 101 requirements. Environmental Services has a checklist form for checking fire sprinkler heads created by the Environmental Services Director to use in making rounds in the building. Environmental Services and / or designee will complete these checklists monthly. Environmental Services and/or designee will bring the completed checklist to the Quality Assurance Committee for review monthly x3 and Quarterly X 4. Environmental Services corrected the wires and conduit resting on top of the sprinkler pipe in the suspended ceiling near room 143. Environmental Services will check all hallway ceilings for wires and conduit resting on top of the sprinkler pipe. Environmental Services will review Regulation NFPA 101 sections of the Life Safety Code. Environmental Services and/or designee will complete audits Quarterly X 4 for wires and conduit resting on top of the sprinkler pipes. Environmental Services will bring Audits to the Quality Committee quarterly x 4 and Annually X 1.	
K 753	Combustible Decorations	K 753		5/27/24

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K 753 SS=D	Continued From page 6 CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not restrict the use of flammable decorations, including candles, in accordance with the requirements of NFPA 101 Life Safety Code, 2012 edition, section 19.7.5.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/02/2024 between 9:15 and 11:30 AM, it was revealed by observation that an unattended candle in a red candle holder was burning in the chapel. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 753	Environmental Services/ Administrator took the Candles out of use in the chapel for correction. Environmental Services and / or designee check the building for other burning candles. The administrator and or designee will speak to the church personnel about the regulation on fire hazards and using the battery operated candles as an option or another option that is not a fire hazard. Environmental services and/or designee will complete Weekly Audits x 2 for monitoring the use of candles in the chapel. Environmental Services and /or designee will bring audits to the Quality Assurance	

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(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 753	Continued From page 7	K 753	committee Quarterly x 1.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245262	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **5/2/2024**
NAME OF PROVIDER OR SUPPLIER **WEST WIND VILLAGE**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 SCOTTS AVENUE MORRIS, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on residents within the facliity. Findings include: On 05/02/2024 between 9:15 and 11:30 AM, it was revealed by observation that empty and full oxygen cylinders were stored in the oxygen storage room without being separated from each other. Violation was corrected at the time of discovery. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 10, 2024

Administrator
West Wind Village
1001 Scotts Avenue
Morris, MN 56267

RE: CCN: 245262
Cycle Start Date: May 1, 2024

Dear Administrator:

On May 1, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 1, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by November 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us