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	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Wind Village	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement donning/doffing of personal protective equipment (PPE) practices for 1 of 3 residents (R4) observed for enhanced barrier precautions (EBP) (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).Findings include: Review of Centers for Disease Control and Prevention (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 included: 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. R4's quarterly Minimal Data Set (MDS) dated [DATE], identified R4 was cognitively intact. R4 had a diagnosis that included an unhealed pressure ulcer, vascular disease (affects blood flow), and hemiplegia (weakness from stroke). R4 was dependent on staff for dressing and activities of daily living (ADLs). R4's diagnosis reported 5/5/26, identified R4 had acquired absence of right leg below the knee as of 5/9/25. R4's care plan revised on 3/27/25, identified R4 needed assistance with ADLs, transferring, and bed mobility. R4's care plan lacked information regarding EBP. R4's signed physician orders identified on 2/9/26, orders received to gently wash open area on the right stump with warm soapy water and pat dry. Apply PluroGel (dressing to maintain moisture) with Prisma (collagen-based wound dressing) to the wound bed and cover with Mepilex (foam dressing) and gauze dressing two days a week, on Monday and Friday. R4's signed physician orders dated 3/31/26, identified R4 had orders started on 3/3/26 to gently wash open area to the right stump with warm soapy water and pat dry. Apply PluroGel with Prisma to the wound bed. Cover with Allevyn dressing every Monday and Friday. R4's signed physician orders dated 4/30/26, identified R4 had a pressure injury to the right knee and to apply Medi-honey (gel to treat wounds), covered by silver alginate, and cover with boarded gauze dressing. R4's electronic medical records (EMAR) for March 2026, identified R4 had a treatment from 3/6/26 to 4/24/26, to wash the open area to the right stump with warm soapy water and pat dry. Apply PluroGel with Prisma to the wound bed. Cover with Allevyn dressing Monday and Friday. R4's EMAR for April 2026, identified R4 received a new order on 4/24/26, to cleanse the stump wound with wound cleanser and pat dry. Apply Medi-honey, covered by silver alginate (antimicrobial dressing), skin prep peri-wound, and allow to dry, apply bordered foam three times a week. Monitor peri-wound skin daily for increasing redness, warmth, or other signs and symptoms of infection. One time a day every Tuesday, Thursday, and Saturday for the right stump wound, no stop date. R4's Medical Device Related Pressure Ulcer Evaluation History printed 5/5/26, identified on 3/2/26, R4 had a stage two pressure ulcer (shallow red wound bed) on the right rear below knee amputation site measuring 1.48 centimeters (cm) by 1.19 cm and was covered by a dressing with no saturation (wound drainage). On 4/13/26, R4 had a stage two pressure ulcer on the right rear below knee amputation site measuring .42 cm by .36 cm and was covered by a dressing with 25% saturation. R4's skin Issue assessment (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE], identified R4 as having a stage two pressure ulcer, which was improving, and was acquired in the facility. Measurements were 1.48 cm by 1.19 cm. R4 had a limb protector on during a transfer. R4 had bumped his stump on a PAL (mechanical lift), and the new skin had come off the wound. Restarted the order for PluroGel and Prisma to wound bed, the medical provider updated. R4's skin Issue assessment dated [DATE], identified R4 had a right below-knee amputation site. Stage two pressure ulcer with partial thickness skin loss with exposed dermis (middle layer of skin), which had an overall wound characteristics improvement, and was acquired in the facility and had been chronic for more than three months. R4's skin Issue assessment dated [DATE], identified R4 as having a stage two pressure ulcer on the right knee amputation site. R4's wound was stable, acquired in the facility, and has been chronic for greater than three months. Progress note dated 4/14/26, revealed R4 having a stage two pressure ulcer, right rear, below the knee amputation site. The wound is greater than three months. No signs and symptoms of infections. Measurements were 0.42 cm by 0.36 cm. 25% saturation on the dressing. Area continues to improve with the current dressing order. R4 denies pain to the area, no signs or symptoms of infection. Progress note dated 4/23/26, revealed R4's right rear below-knee amputation site was a stage two pressure ulcer with partial thickness skin loss with exposed dermis. Wound acquired in the facility. The wound was greater than three months. No undermining, no tunneling. R4 seen by the provider for wound care. New orders to clean wound with wound cleanser, pat dry, apply Medi-honey, covered by silver alginate, skin prep peri wound, and allow to dry, apply bordered foam three times a week. Monitor peri-wound skin daily for increasing redness, warmth, or other signs and symptoms of infection. R4's progress notes dated 4/30/26, revealed R4 was seen by the wound provider. Wound was stable and appeared to be improving. Continue Medi-honey, covered by silver alginate, and cover with bordered gauze dressing. During an interview/observation on 5/5/26 at 8:51 a.m., license practical nurse (LPN)-A sanitized scissors with an alcohol wipe, gathered alevin dressing, gauze dressings, Med-honey, wound spray cleaner, gloves, skin prep, and brought supplies into the room. LPN -A washed hands and applied gloves. LPN did not apply a gown, and there was no sign on R4's door of being on EBP. There were no gowns outside of R4's room or inside of R4's room. LPN-A indicated the wound was on the top of the right stump. LPN -A removed the old dressing and reported there was a scant amount of drainage on the dressing, which was yellow in color. No signs of infection. LPN-A cleansed the wound with wound wash. LPN-A indicated the wound would be measured with the wound nurse on Thursday and did not have a measuring device, but the wound appears to be approximately 0.5 cm by 0.5 cm and is red around the open wound, and the area appeared to be healing. The LPN-A took off the gloves and sanitized hands. LPN-A applied new gloves, took the Medi-honey and placed on the wound, and covered it with silver alginate. LPN-A used the skin prep around the wound, and the Allevyn dressing was applied. LPN-A indicated the facility received new wound care orders the previous week from the wound nurse. LPN-A indicated R4 had an open area last fall on his right stump but was healed until R4 bumped his stump on something. R4 wound is chronic as R4 has a bone that rubs against the skin and will open up when area is rubbed against something or bumped. LPN-A indicated the wound had been open for over a month. LPN -A indicated that gowns were to be worn if a resident had MRSA or tested positive for an organism that warranted the use of gowns, but did not believe gowns needed to be worn for R4's dressing change. During an interview on 5/5/26 at 12:01 p.m., nursing assistant (NA)-B indicated she did not wear a gown when providing ADLs as R4 did not have Clostridium difficile (c. diff) or a contagious organism and was not on EBP. During an interview on 5/5/26 at 1:53 p.m., infection preventionist (IP) indicated R4 had an open wound on his right stump and had been open for a few months. IP indicated there is a bone under the skin and when R4 rubs the skin on something, the area opens up. IP verified R4 had not been placed on EBP, and staff had not been wearing gowns when doing the dressing changes. During an interview on 5/5/26 at 2:17 p.m., director of nursing (DON) indicated her expectation was for staff to use EBP when working with a resident who has an indwelling medical device or a chronic open wound. DON would expect staff to wear gowns when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing high-contact care such as transfers, dressing, wound changes, and ADLs. DON indicated this is important to prevent multidrug resistant organisms (MDROs). Policy titled Enhanced Barrier Precautions dated 3/10/26, identified EBP should also be used for residents with chronic wounds and/or indwelling medical devices (e.g., urinary catheters, feeding tubes, central line, tracheostomy). Chronic wounds are defined as pressure ulcer, diabetic foot ulcer, unhealed surgical wound, and venous stasis ulcer. Skin breaks or skin tears are not considered a chronic wound. Indwelling medical devices are defined as urinary catheter, feeding tube, central line, and tracheostomy. A peripheral intravenous line is not considered an indwelling medical device. EBP are employed when performing the following high-contact resident care activities: dressing, bathing/showering, changing linen, transferring, hygiene care, toileting/peri care/emptying catheter bag, wound care, indwelling medical device care, therapy treatment. EBP will remain in place for the resident stay or until resolution of the wound or discontinuation of the medical indwelling device. Staff who are not engaging in high-contact resident care activities will not need to employ EBP while interacting with the residents (e.g., answering a call light, verbally conversing, or during medication administration). The facility failed to use EBP for residents with chronic wounds.