Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 12, 2026

Administrator
West Wind Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

RE: CCN: 245262
Cycle Start Date: May 6, 2026

Dear Administrator:

On June 4, 2026, the Minnesota Department(s) 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.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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May 14, 2026

Administrator
West Wind Village
1001 SCOTTS AVENUE
MORRIS, MN 56267

RE: CCN:245262
Cycle Start Date: May 6, 2026

Dear Administrator:

On May 6, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

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 6, 2026 (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 6, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Wind Village	**1001 SCOTTS AVENUE , MORRIS, Minnesota, 56267**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 5/4/26 to 5/6/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		05/14/2026
F0000	INITIAL COMMENTS On 5/4/26 to 5/6/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52621726C (2989371), H52621727C (2986450). NO deficiencies were cited. 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 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 substantial compliance with the regulations has been attained.	F0000		05/14/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide	F0880	Enhanced Barrier Precautions (EBP) were implemented for R4 due to his open wound. The nursing staff were educated on his EBP use, and his care plan and orders updated. Residents that have chronic open wounds could be affected by this. All residents that have wounds were assessed to ensure that EBP was implemented. If	06/03/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

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F0880 SS = D	Continued from page 1 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 §483.71 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, 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.	F0880	Continued from page 1 any were found not to have EBP implemented the IPCO or designee implemented EBP. The DON or designee reviewed the Enhanced Barrier Precaution policy. No Revisions were made. The DON or designee educated nurses on when to implement EBP and how to use it properly. All nursing staff and therapy staff were also trained in the correct use of EBP and the policy. The DON or designee will do audits to ensure that EBP is implemented for chronic open wounds. This will be done 2x/week for 2 weeks, 1x/week for 2 weeks. Findings will be brought to QAPI to see if further auditing should be done, along with the duration of the audit.	06/03/2026

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F0880 SS = D	Continued from page 2 §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 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 2/20/2026, 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	F0880		06/03/2026

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F0880 SS = D	Continued from page 3 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 dated 3/2/26, 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 3/12/26, 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	F0880		06/03/2026

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F0880 SS = D	Continued from page 4 more than three months. R4's skin Issue assessment dated 4/13/26, 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	F0880		06/03/2026

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F0880 SS = D	Continued from page 5 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 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).	F0880		06/03/2026

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F0880 SS = D	Continued from page 6 The facility failed to use EBP for residents with chronic wounds.	F0880		06/03/2026

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	245262	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/07/2026**

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West Wind Village	**1001 SCOTTS AVENUE , MORRIS, Minnesota, 56267**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/07/2026. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K0000		05/14/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245262	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	Continued from page 1 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 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 45 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/14/2026

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K0222 SS = D Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed	K0222	On 5/7/26, the delayed egress door in Loher Lane was adjusted to open at 15-seconds as indicated on the sign posted. The egress door in Loher Lane will be inspected monthly for 3 months and reported to the Quality Assurance Performance Improvement Committee for review. If there are no continuing issues, doors will then be inspected during the regular inspection audit that takes place annually. Environmental Services and or designee is responsible for corrective action, monitoring and compliance with delayed egress doors.	06/03/2026

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K0222 SS = D Bldg. 01	Continued from page 3 in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain delayed egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.4, and 7.2.1.6.1.1(3). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/07/2026 at 12:01 PM, it was revealed by observation that the delayed egress door in Loher Lane has a sign on it indicating that it will open in 15-seconds, but when the door was tested it opened at 30-seconds. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0222		06/03/2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous	K0321	On 5/7/26, the door for the Soiled Utility Room in Pacific Lane was adjusted to positively latch when closed using the self-closing device. The Soiled Utility Room door in Pacific Lane will be inspected monthly for 3 months and reported to the Quality Assurance Performance Improvement Committee for review. If there are no continuing issues, doors will then be inspected during the regular inspection audit that takes place annually. Environmental Services and or designee is responsible for corrective action, monitoring and compliance with positively latching doors.	06/03/2026

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K0321 SS = D Bldg. 01	Continued from page 4 areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.6.3.5. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/07/2026 at 12:09 PM, it was revealed by observation that the door for the Soiled Utility Room in Pacific Lane did not positively latch when closed using the self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		06/03/2026
K0353 SS = D Bldg. 01	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.	K0353	On 5/7/26, the sprinkler head escutcheon plate in the Wells Park Clean Linen Room was restored. The sprinkler head escutcheon plate in the Wells Park Clean Linen Room will be inspected monthly for 3 months and reported to the Quality Assurance Performance Improvement Committee for review. If there are no continuing issues, sprinkler heads will be	06/03/2026

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K0353 SS = D Bldg. 01	Continued from page 5 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler systems 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, section 5.2.1.1.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 05/07/2026 at 12:19 PM, it was revealed by observation that the sprinkler head in the Wells Park Clean Linen Room was missing an escutcheon plate. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 5 inspected during the regular inspection audit that takes place semi-annually. Environmental Services and or designee is responsible for corrective action, monitoring and compliance with sprinkler heads.	06/03/2026