



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2026

Administrator
THE GARDENS AT WINSTED LLC
551 FOURTH STREET NORTH
WINSTED, MN 55395

RE: CCN:245459
Cycle Start Date: July 24, 2026

Dear Administrator:

On July 24, 2026, 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:

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

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 October 24, 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 January 24, 2027 (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,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

Administrator
THE GARDENS AT WINSTED LLC
551 FOURTH STREET NORTH
WINSTED, MN 55395

Re: State Nursing Home Licensing Orders

Event ID: 231A8B-H1

Dear Administrator:

The above facility survey was completed on July 24, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01,

available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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 7/20/26 through 7/24/26, 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			
F0000	INITIAL COMMENTS On 7/20/26 through 7/24/26, a standard recertification survey (S#S5459041) 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 with NO deficiencies were cited: H54593238C (2679205); H54593239C (2683146); H54593235C (2684261); H54593234C (2988432); H54593240C (1177774). 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			

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: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents' call lights were responded to timely to meet resident needs for 5 of 6 residents (R4, R6, R13, R20, and R38) reviewed for call light response times. This failure resulted in residents experiencing prolonged wait times for assistance and placed residents at risk for unmet care needs, including toileting, hygiene, and other requests for assistance. Findings include:			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 2 R4's quarterly Minimum Data Set (MDS), dated 6/4/26, indicated R4 was cognitively intact, and diagnoses included chronic respiratory failure, heart failure, and anxiety disorder. R4 had lower extremity impairment on both sides, used a wheelchair, was dependent on staff for dressing, transfers, and toileting, and was frequently incontinent. During an interview on 7/20/25 at 2:23 p.m., R4 stated she was concerned about long call light times. During an interview on 7/22/26 at 3:56 p.m., nursing assistant (NA)-C stated R4 used her call light frequently and required the assistance of 2 staff with transfers with a mechanical lift. Review of R4's call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 6/24/26 at 12:51 p.m. - response time 44 minutes 6/25/26 at 5:47p.m. - response time 68 minutes 6/25/26 at 8:11 p.m. - response time 61 minutes 6/27/26 at 6:21 p.m. - response time 33 minutes 6/28/26 at 10:37 a.m. - response time 44 minutes 6/28/26 at 6:57 p.m. - response time 57 minutes 6/28/26 at 8:43 p.m. - response time 39 minutes 6/29/26 at 6:34 a.m. - response time 55 minutes 6/29/26 at 12:49 p.m. - response time 45 minutes 6/29/26 at 3:24 p.m. - response time 33 minutes 6/29/26 at 5:57 p.m. - response time 70 minutes 6/30/26 at 6:29 p.m. - response time 67 minutes 7/1/26 at 5:37 p.m. - response time 49 minutes 7/1/26 at 6:38 p.m. - response time 38 minutes 7/1/26 at 8:30 p.m. - response time 45 minutes 7/2/26 at 6:14 p.m. - response time 37 minutes			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 3 7/2/26 at 9:10 p.m. - response time 67 minutes 7/3/26 at 11:28 a.m. - response time 77 minutes 7/3/26 at 2:46 p.m. - response time 39 minutes 7/3/26 at 5:38 p.m. - response time 43 minutes 7/4/26 at 12:26 p.m. - response time 66 minutes 7/4/26 at 6:01 p.m. - response time 47 minutes 7/5/26 at 12:35 p.m. - response time 44 minutes 7/5/26 at 6:08 p.m. - response time 56 minutes 7/5/26 at 8:44 p.m. - response time 53 minutes 7/6/26 at 8:08 p.m. - response time 39 minutes 7/6/26 at 6:25 p.m. - response time 51 minutes 7/6/26 at 7:26 p.m. - response time 40 minutes 7/7/26 at 6:09 p.m. - response time 38 minutes 7/7/26 at 7:45 p.m. - response time 74 minutes 7/8/26 at 7:17 a.m. - response time 46 minutes 7/8/26 at 10:17 a.m. - response time 31 minutes 7/8/26 at 6:52 p.m. - response time 53 minutes 7/8/26 at 9:36 p.m. – response time 43 minutes 7/11/26 at 4:29 p.m. - response time 30 minutes 7/11/26 at 5:54 p.m. - response time 54 minutes 7/13/26 at 5:10 p.m. - response time 38 minutes 7/14/26 at 12:15 p.m. - response time 30 minutes 7/14/26 at 7:08 p.m. - response time 60 minutes 7/15/26 at 4:50 p.m. - response time 46 minutes 7/15/26 at 6:06 p.m. - response time 63 minutes 7/16/26 at 4:49 p.m. - response time 32 minutes 7/16/26 at 8:08 p.m. - response time 34 minutes 7/17/26 at 6:22 a.m. - response time 36 minutes			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 4 7/17/26 at 12:09 p.m. - response time 50 minutes 7/18/26 at 3:37 p.m. - response time 30 minutes 7/18/26 at 4:07 p.m. - response time 39 minutes 7/19/26 at 3:06 p.m. - response time 42 minutes 7/19/26 at 5:58 p.m. - response time 68 minutes 7/20/26 at 6:07 p.m. - response time 67 minutes 7/21/26 at 4:59 p.m. - response time 92 minutes 7/22/26 at 6:39 p.m. - response time 36 minutes R6’s quarterly Minimum Data Set (MDS), dated 6/11/26, indicated R6 was cognitively intact, required staff assistance with toileting, had an indwelling catheter and was incontinent of bowel. R6’s diagnoses included Crohn’s disease (long-term type if inflammatory bowel disease), urinary tract infection, muscle weakness, chronic pain, neuromuscular dysfunction of bladder (lack of bladder control caused by brain, spinal cord or nerve damage), and neurogenic bowel (loss of normal bowel control and function). During an interview on 7/21/26 at 11:09 a.m., R6 stated she had complained several times that the call light was on for up to an hour waiting for staff to assist with incontinent cares. R6 stated she ends up sitting in a bowel movement for extended periods of time resulting in bladder infections. Review of R6’s call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 6/22/26 at 6:09 p.m. - response time 115 minutes 6/22/26 at 9:04 p.m. – response time 60 minutes 6/25/26 at 6:23 p.m. – response time 39 minutes 6/25/26 at 7:49 p.m. – response time 71 minutes 6/26/26 at 11:11 a.m. – response time 53 minutes 6/26/26 at 8:46 p.m. – response time 85 minutes			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 5 6/27/26 at 9:14 p.m. – response time 31 minutes 6/29/26 at 10:24 a.m. – response time 32 minutes 6/29/26 at 7:39 p.m. – response time 80 minutes 7/1/26 at 4:24 p.m. - response time 38 minutes 7/1/26 5:41 p.m. - response time 44 minutes 7/1/26 at 7:23 p.m. - response time 32 minutes 7/2/26 at 12:33 p.m. - response time 47 minutes 7/2/26 at 6:40 p.m. - response time 62 minutes 7/2/26 at 9:16 p.m. - response time 53 minutes 7/3/26 at 6:44 p.m. – response time 69 minutes 7/6/26 at 8:33 a.m. – response time 42 minutes 7/7/26 at 2:45 p.m. – response time 51 minutes 7/7/26 at 8:07 p.m. - response time 36 minutes 7/8/26 at 6:29 p.m. - response time 47 minutes 7/10/26 at 1:25 p.m. - response time 37 minutes 7/10/26 at 5:37 p.m. - response time 50 minutes 7/11/26 at 6:58 p.m. - response time 37 minutes 7/13/26 at 4:49 p.m. - response time 45 minutes 7/13/26 at 9:32 p.m. - response time 32 minutes 7/14/26 at 5:37 p.m. - response time 61 minutes 7/14/26 at 7:11 p.m. - response time 36 minutes 7/14/26 at 8:47 p.m. - response time 37 minutes 7/15/26 at 3:57 p.m. - response time 136 minutes 7/16/26 at 7:39 p.m. - response time 44 minutes 7/18/26 at 9:15 a.m. – response time 48 minutes 7/19/26 at 8:43 p.m. – response time 47 minutes 7/20/26 at 5:26 p.m. - response time 67 minutes R13’s quarterly MDS, dated 4/24/26, indicated R13			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 6 was cognitively intact, diagnoses included hip fracture, traumatic brain injury (TBI), and depression. R13 had lower extremity impairment on both sides, used a wheelchair, required assistance with transfers, and was frequently incontinent. On 7/22/26 at 9:38 a.m., R13 stated she was concerned about long call light times. R13 stated, “I’m 41 years old. You don’t want to be incontinent.” Review of R13’s call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 6/21/26 at 11:01 a.m. - response time 34 minutes 6/22/26 at 9:00 p.m. - response time 68 minutes 6/28/26 10:53 a.m. - response time 32 minutes 7/1/26 at 8:14 p.m. - response time 31 minutes 7/2/26 at 7:13 p.m. - response time 56 minutes 7/3/26 at 9:36 p.m. - response time 38 minutes 7/7/26 at 10:29 a.m. - response time 39 minutes 7/13/26 at 6:08 p.m. - response time 62 minutes 7/15/26 at 6:40 p.m. - response time 40 minutes 7/20/26 at 10:39 a.m. - response time 48 minutes 7/20/26 at 3:37 p.m. - response time 87 minutes During an interview on 7/23/25 at 3:54 p.m., nursing assistant (NA)-C stated call lights showed on the central monitor at the nurses' station and on the scroll boards. NA-C stated the busiest time for call lights was after supper, between 6:00 p.m. to 8:00 p.m. During an interview on 7/24/26 at 10:36 a.m., NA-F stated staff answered call lights in the order they were pushed, provided cares, and then went to the next resident until all call lights were answered. R20’s admission MDS, dated 6/16/26, indicated R20			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 7 was cognitively intact and required assistance from staff with activities of daily living (ADLs). R20's diagnoses included emphysema (lung disease), major depression, panic disorder, post-traumatic stress disorder, and anxiety. On 7/20/26 at 10:40 a.m., an odor of urine was noted in R20's room, and a bedpan was observed on the floor under R20's bed. R20 stated there were several times the call light was on and R20 had to wait for staff to come for over half an hour. Review of R20's call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 7/2/26 at 4:32 p.m. - response time 41 minutes 7/3/26 at 4:33 p.m. - response time 46 minutes 7/4/26 at 6:21 p.m. - response time 56 minutes 7/5/26 at 6:39 a.m. – response time 63 minutes 7/16/26 at 4:29 p.m. – response time 32 minutes R38's care plan, dated 7/14/26, indicated R38 had an alteration in bladder and bowel elimination, with identified interventions of assist of one with toileting needs. R38's diagnoses included weakness, diabetes, edema and peripheral autonomic neuropathy (damage to peripheral nerves that control involuntary body functions like heart rate, digestion and sweating, common symptom included urinary incontinence. R38's bladder evaluation, dated 7/13/26, indicated R38 had urge incontinence which includes symptoms of strong uncontrolled urgency, frequency of urination, moderate to large amount of urine leakage and enuresis (bedwetting). During an interview on 7/20/26 at 11:41 a.m., R38 stated when the call light was turned on, he waited half an hour or more and has ended up sitting in urine-soaked sheets while waiting for the staff to answer the call light.			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 8 Review of R38’s call light logs from 7/13/26-7/22/26, identified multiple call light response times greater than 30 minutes: 7/13/26 at 5:06 p.m. – response time 41 minutes 7/16/26 at 1:06 a.m. – response time 34 minutes 7/16/26 at 3:40 a.m. - response time 56 minutes 7/16/26 at 2:30 p.m. – response time 48 minutes 7/16/26 at 5:35 p.m. - response time 89 minutes 7/16/26 at 9:31 p.m. - response time 36 minutes 7/17/26 at 5:04 a.m. – response time 40 minutes 7/18/26 at 9:25 a.m. - response time 39 minutes During an interview on 7/24/26 at 10:47 a.m., anonymous staff A stated the call boards in the hallways were broken, and staff could only tell when call lights were on was from the nurses’ station. Anonymous A stated there were pagers staff wore that alerted them to call lights, but the director of nursing (DON) got rid of those. Anonymous B stated the call light board in the transitional care unit was not working, the call board by the nurses’ desk worked periodically, and call board at the end of the hall was broken, faced the floor and had been that way for a while. During an interview on 7/24/26 at 1:25 p.m., registered nurse (RN)-C stated call lights were expected to be answered within 8-10 minutes. During an interview on 7/24/26 at 1:29 p.m., DON stated when staff were in rooms, the staff would not know what call lights were on, so staff were expected to check boards or the screen when they came out of a resident’s room. DON stated the staff were expected to look at the call light boards in the hallways or the screen at the nurses’ desk. DON stated there had been occasional issues with the call lights not running due to wi-fi issues. DON stated she was not aware one of the boards was facing the floor.			F0725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0725 SS = E	Continued from page 9 During an interview on 7/24/26 at 2:24 p.m., administrator stated they had completed call light audits on the floor, they had waited at the nurses' station for one to go on and watched the screen to see how long it took for the staff to turn them off. Administrator acknowledged they did not run call light logs to review for long call light times unless a resident had complained. The facility's Call Light policy, updated 5/16/23, indicated call lights must relay the call to a staff member or centralized location where staff were working such as the nurses' station, however, the policy did not address the timing for call lights to be answered.			F0725			
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to maintain the walk-in freezer in a clean and safe condition, as evidenced by a large accumulation of ice on the freezer floor and on stored food boxes, and spilled food items. The facility failed to maintain the dining room resident refrigerator/freezer as evidenced by spilled			F0812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0812 SS = E	Continued from page 10 and undated food items. Additionally, the facility failed to ensure staff completed hand hygiene and wore the appropriate hair coverings in the kitchen. This had the potential to affect all 32 residents residing in the facility. Findings include: During an observation on 07/20/2026 at 9:51 a.m., of the walk-in freezer, a large accumulation of ice was observed on the floor at the end of the shelving on the right side of the freezer. The mound of ice measured approximately 18 inches high with a base measuring approximately 3 feet by 2 feet. A separate chunk of ice measuring approximately 4 inches thick by 6 inches long by 5 inches wide was observed resting on top of a box. Another box stored in the corner had a coating of ice on the top and side. The food items inside the boxes were not observed to be frozen together or covered with ice. During an interview on 07/20/2026 at 9:51 a.m., head cook (HC) stated he had not been at the facility for five days and the ice accumulation was not present the last time he had worked. On 07/20/2026 at 12:50 p.m., the walk-in freezer was observed with regional culinary director (RCD). RCD stated the ice mound should have been taken care of long before this for safety. RCD stated, “Someone could come in and slip, and the food could get affected with the ice on the boxes.” He further stated it likely had taken approximately three to four months for the ice accumulation to reach its observed size. During an observation on 7/22/26 at 10:30a.m., dietary aide (DA)-A was observed positioned between the stove and metal table mopping the floor. DA-A had a full beard with no cover in place and his hair pulled back in a tail at the back of his neck with no hair cover. The dietary manager (DM) acknowledged DA-A should have a facial hair cover when in the kitchen and directed DA-A to go and apply one. During an interview on 7/22/26 at 10:35 a.m., DA-A reported he usually applied a facial hair cover when entering the kitchen area, but he had forgotten.			F0812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0812 SS = E	Continued from page 11 During a meal service observation on 7/22/26 at 11:19 a.m., nursing assistant (NA)-D entered the kitchen area with her hair in a long ponytail and no hair net. Additionally, NA-D failed to perform hand hygiene upon entering the kitchen area. NA-D went to the walk-in cooler, entered, and returned carrying a glass of milk. During an interview on 7/22/26 at 11:23 a.m., NA-D reported she was retrieving a glass of milk upon a resident's request. NA-D confirmed she had not applied a hairnet, nor performed hand hygiene prior to entering the kitchen area. NA-D reported she should have applied a hairnet, and washed her hands, or requested dietary staff to retrieve the milk, instead of walking into the kitchen area. The DM observed the incident and stated staff walking into the kitchen was not acceptable practice and had been an ongoing issue with unauthorized staff walking into the kitchen. During an observation on 7/22/26 at 12:15 p.m., with the DM of the resident refrigerator/freezer located in the dining room the freezer compartment contained an approximate 1/2-inch layer of ice on the floor of the freezer. The following opened and undated items were in the freezer: 1.5-quart container of Casey's Carmel Cone Sunday ice cream, and a loaf of opened, undated Artesano Hawaiian bread. The door seal contained a granular black substance and food particles, and food particles were noted on the bottom and shelves to the freezer. The refrigerator section contained the following opened and undated items: an opened carton of "Top the Tator" sour cream dip, four plastic containers of pickles, a paper Culvers bag with a sandwich and fries. The seal of the refrigerator door had a black granular substance in the seal and hinge area of the door. The door frame, shelves, and bottom of the refrigerator contained spilled food particles. During an interview on 7/22/26 at 11:29 a.m., DM stated the cleaning schedule indicated the refrigerator had last been cleaned on 7/21/26, but it had not been cleaned according to DM's expectations. DM stated food placed in the resident refrigerator was expected to be written on the log posted on the front of the refrigerator, and was to include the date, placed in the refrigerator, name, date the item was opened.			F0812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0812 SS = E	Continued from page 12 The facility's Refrigerators and Freezers policy, revised 12/2014, indicated supervisors would inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs, and manufacturer maintenance guidelines would be scheduled and followed. The facility's Food Brought by Family/Visitors policy, revised October 2017, indicated food brought by family or visitors and left for the resident to consume later was to be labeled and stored in a manner distinguishable from facility-prepared food. Non-perishable foods must be stored in re-sealable containers with tight-fitting lids. Perishable foods must be stored in re-sealable containers with tight fitting lids in a refrigerator. Containers must be labeled with the resident's name, the item, and the "use by" date. Nursing staff will discard perishable foods on or before the "use by" date. The nursing and/food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger.			F0812			
F0882 SS = E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP)			F0882			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0882 SS = E	Continued from page 13 who was also the director of nursing (DON) had appropriate oversight of the infection control (IC) program that included employee surveillance of all employees. This had the potential to affect all 32 residents. Findings include: Review of facility infection control surveillance documents identified the infection preventionist (IP) managed resident illness surveillance, which was included in the infection control surveillance documentation. However, no employee surveillance was included in the infection control surveillance documentation. During an interview on 7/22/26 at 10:23 a.m., the director of nursing/infection preventionist (DON/IP) stated she had nothing to do with tracking or managing employee illness. DON/IP stated employee illness was tracked and managed by the human resources (HR)/scheduling coordinator. The DON/IP stated when an employee called in sick, the scheduling coordinator received the call and tracked their illness by asking the appropriate questions per policy and procedure. The DON/IP reported employee illnesses (call-ins) were discussed during the morning meeting which allowed nursing to add in any suspected correlation between employee illness and resident illness. The DON/IP identified she did not maintain documentation of the morning meetings. During an interview on 7/22/26 at 2:32 p.m., the staffing coordinator (SC) stated when a staff person called-in ill, they were to call both the facility and the staffing phone to notify the department head which staff were calling in and administration. SC reported she primarily delt with nursing staff and when she received a call-in, she attempted to find a replacement. SC identified the forms filled out for staff call-ins were kept in the scheduling binder in her office. SC stated she was not responsible for activity, or culinary staff and managers of those departments managed their own staff call-ins. Review of the forms filled out for staff call-ins indicated the following: -Nursing assistant (NA)-E had called-in on 4/22/26 with reported symptoms of diarrhea beginning			F0882			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0882 SS = E	Continued from page 14 4/20/26 through 4/22/26. NA-E returned to work on 4/25/26, but there was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure NA-E was safe to return to work, or if NA-E had been prohibited from work for an appropriate amount of time. NA-E's time punches were requested but not provided. -NA-C left her shift on 4/5/26 with complaints of nausea and returned to work on 4/19/26. There was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure staff were safe to return to work, or if NA-C had been prohibited from work for an appropriate amount of time. NA-C's time punches were requested but not provided. -Cook-A called-in with vomiting on 5/3/26, reported symptoms resolved on 5/4/26 and returned to her shift in dietary on 5/5/26. There was no indication if the facility had followed infection control standards for criteria in-order to ensure cook-A was safe to return to work, or if cook-A had been prohibited from work for an appropriate amount of time. Cook-A's time punches identified she was off 5/3/26-5/4/26 and returned on 5/5/26. -Dietary Aid (DA)-A called-in on 6/30/26 with complaints of nausea, no additional data was provided and review of DA-A's timecard identified he returned to his shift in the dietary department the next day, on 7/1/26. There was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure DA-A was safe to return to work, or if DA-A had been prohibited from work for an appropriate amount of time. During an interview on 7/22/26 at 4:15 p.m., with the dietary manager (DM) reviewed timecards for the two dietary staff that had call-in with GI symptoms and identified he had followed the MN policy posted in the kitchen which listed an employee must wait 24 hours from their last symptom before returning to work. DM stated cook-A had started her shift on 5/5/26 at 5:00 a.m. which was not within the required time from her last symptom. DM also reported he had been out on leave from 6/15/26 through 7/21/26 and did not know who was overseeing the monitoring of illness for dietary department when he was out on leave, but he			F0882			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0882 SS = E	Continued from page 15 assumed someone had. The Infection Preventionist job description identified the IP was responsible to evaluate practice in culinary, laundry, housekeeping, maintenance, and nursing departments to ensure consistency with recommended infection control standards. The IP conducts ongoing infection surveillance, compiles and analyzes data, and prepares reports for presentation to the Infection Prevention and Control Oversight Committee. The facility's Infection Prevention and Control Program policy, dated 4/26/26, indicated it was comprehensive and addressed detection, prevention, and control of infections among residents and personnel. The infection prevention and control program is coordinated and overseen by the IP. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Surveillance tools are used for recognizing the occurrence of infection, recording their number and frequency, detecting outbreaks, monitoring employee infections, and detecting unusual pathogens with infection control implications. The major elements of the program included coordination/oversight, surveillance, outbreak management, prevention of infection, and employee health.			F0882			
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed for all medications kept at bedside for 3 of 3 residents (R1, R13, R30) observed with medications at their bedside. Findings include: R1's significant change Minimum Data Set (MDS), dated 6/23/26, indicated R1 was cognitively intact and required assistance with activities of daily living.			F0554			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0554 SS = D	Continued from page 16 R1's diagnoses included respiratory failure, chronic pain, anxiety, and asthma. R1's Order Summary Report, printed 7/27/26, indicated R1 had an order for Ventolin HFA Inhalation Aerosol Solution (short acting inhaler, relaxes tight muscles in the airway) 108 micrograms/actuation (Mcg/Act) 2 puffs inhale every four hours as needed for shortness of breath. The summary report also indicated R1 had an order dated 1/28/26 for okay to self-administer inhalers at bedside after set-up pending nursing assessment of self-administration. R1's Self Administration of Medication (SAM) Evaluation, dated 6/23/26, indicated per staff resident no longer self-administered any medications or creams. "She used to but no longer does self-administer nor does she request to do so". During an observation on 7/22/26 at 3:02 p.m., R1's Ventolin inhaler was observed on the overbed table next to R1's bed, within reach of R1. During an observation on 7/23/26 at 8:29 a.m., R1's inhaler was observed on top of overbed table next to R1's bed. During an interview on 7/23/2026 1:47 p.m., registered nurse (RN)-A stated R1 had an inhaler but it was no longer kept at her bedside. RN-A stated the nurse manager or the director of nursing (DON) completed the self-administration of medications assessments. During an interview on 7/24/26 at 1:04 p.m., RN-C stated R1 needed to demonstrate how to use the inhaler correctly and verbalize when to use the inhaler. RN-C reviewed R1's assessment and verified RN-C's name was on the assessment as having completed the assessment for R1. R13's quarterly MDS, dated 4/24/26, indicated R13 was cognitively intact, and diagnoses included traumatic brain injury (TBI), diabetes, and asthma. On 7/20/26 at 9:38 a.m., a medication cup with 9			F0554			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0554 SS = D	Continued from page 17 tablets/capsules was observed on R13’s bedside table. R13 stated she had just woken up and found the medication left at her bedside. During an observation on 7/21/26 at 9:34 a.m., a medication cup with 8.5 tablets/capsules was observed on R13’s bedside table. R13 was not in the room at the time. On 7/22/26 at 9:25 a.m., a medication cup with tablets/capsules was observed on R13’s bedside table. R13 stated medications had been left at bedside for at least 6 months. R13’s Order Summary Report, dated 7/8/26, indicated R13 had an order dated 5/11/26 for may self-administer medication after nursing setup. R13’s SAM Evaluation, dated 5/13/26, indicated R13 was safe to self-administer medication after nursing set up, and inhalers and lozenges kept at bedside. R13’s SAM Evaluation, dated 5/25/26, indicated R13 was able to keep inhaler and lozenges at bedside and self-administer inhalers as ordered, and was able to self-apply lotions and ointments after nursing set up. The evaluation further indicated, “All other medications will be set up and administered by nursing as there have been multiple events of resident forgetting to take medications after they area [sic] set up and left with resident, resulting in missed doses”. However, R13’s electronic health record (EHR) lacked evidence the 5/25/26 SAM evaluation results had been communicated to the provider. Additionally, the EHR lacked evidence R13’s orders and care plan had been updated to reflect the updated evaluation findings. R13’s Medication Administration Record (MAR), dated July 2026, indicated “ok to leave tizanidine and Lyrica at bedside”, with a start date of 7/14/26. However, no other medications were ordered as okay to leave at bedside. During an interview on 7/22/26 at 9:44 a.m., RN-B stated he had set up R13’s medications that day.			F0554			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0554 SS = D	Continued from page 18 RN-B stated he left the medications at the bedside for R13 as allowed per provider orders. R30's quarterly MDS, dated 7/1/26, indicated R30 was cognitively intact and diagnoses included hepatic encephalopathy (a worsening of brain function when a damaged liver can no longer remove toxic substances from the blood), heart failure, and diabetes. R30's SAM Evaluation, dated 4/21/26, indicated R30 was not reliably safe to self-administer medications. Additionally, the evaluation did not indicate that R30 was able to keep any medications at bedside. On 7/21/26 at 10:38 a.m., fluticasone propionate nasal spray was observed at R30's bedside. R30 stated she normally self-administered the nasal spray. R30's MAR, dated July 2026, indicated R30 had an order for Fluticasone Propionate nasal suspension 50 mcg/act 2 spray in each nostril two times a day for allergic rhinitis. No orders for self-administration or medications at bedside were indicated on the MAR. During an interview on 7/24/26 at 11:12 a.m., director of nursing (DON) verified R13's SAM evaluation indicated she was not safe to self-administer medications. The facility's Self-Administration of Medications policy, dated 2/2024, indicated the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.			F0554			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide reasonable accommodation of needs and preferences for 1 of 1 resident (R28) reviewed for environmental scents. Findings include: R28’s quarterly Minimum Data Set (MDS), dated 5/18/26, indicated R28 was cognitively intact, and diagnoses included diabetes, heart failure, asthma, and allergies. R28’s care plan, last revised 5/21/26, indicated R28 had multiple allergies and intolerances, many allergies to different scents, and required assist of one with bathing. During an interview on 7/20/26 at 2:30 p.m., R28 stated she does not participate in activities due to allergies and used an N-95 mask to provide scent blockage. R28 stated because of the chemicals and fragrances used in the shower room, she did not get her scheduled shower. R28 stated she has gone up to three weeks a couple of times without showers. R28 stated that one time staff had her use the shower room before any other residents and she showered without any issues. During an interview on 7/23/26 at 2:12 p.m., nursing assistant (NA)-D stated R28 was very sensitive to smells and wore a mask a lot. During an interview on 7/23/26 at 3:49 p.m., NA-E stated R28 required supervision with showers, and R28 was very sensitive to scents or odors. During an interview on 7/24/26 at 10:31 a.m., environmental service (ES) stated the facility took residents' sensitivity to chemical smells seriously.			F0558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0558 SS = D	Continued from page 20 ES stated R28 had a sign on her door that it is a scent-free room due to R28’s allergies, and staff followed the posted restrictions. ES stated the employee handbook instructed staff to not wear strong perfume or extra aroma items because it showed respect for the residents. During an interview on 7/24/26 at 2:46 p.m., registered nurse manager (RN)-C stated the facility made arrangements one time for R28 to be offered the first shower of the day. RN-C stated R28 has not requested the first shower of the day since. The facility's Employee Handbook 2026 indicated scents must be limited and barely perceptible, in recognition of resident sensitivities and allergies.			F0558			
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the			F0604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0604 SS = D	Continued from page 21 need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident remained free from physical restraints not required to treat a medical symptom when the facility incorporated the use of law enforcement handcuffs into resident's care plan for 1 of 1 resident (R45) reviewed for restraints. Findings include: R45's admission record, printed 7/24/26, indicated R45 admitted to the facility on 7/20/26, and diagnoses included abdominal aortic aneurysm without rupture and diabetes. R45's care plan, initiated 7/21/26, indicated a physical restraint was "deemed necessary" by county policy due to R45's criminal history. The care plan indicated corrections staff would remain in R45's room or observe R45 "at all times". The care plan further indicated R45 would be handcuffed if security left the room, and security staff would place and remove handcuffs for the resident. However, the care plan also indicated staff would place and remove handcuffs PRN (as needed). R45's Informed Consent for Use of Physical Restraints, signed 7/21/26, listed the type of restraint as "handcuffs when not in vision of security guard due to the need for 24-hour supervision related to admitting to hospital and SNF from jail". R45's Order Summary Report, dated 7/24/26, indicated an order "OK to apply handcuffs to resident as needed for safety every shift", with a start date of 7/21/26. However, the order did not identify a medical symptom that warranted the use of the restraint. During an interview on 7/24/26 at 10:47 a.m., anonymous staff A stated there was an inmate in the facility. Staff had been instructed to provide a shower for R45 with two staff present, the guard was to remain in the room and R45 was to be handcuffed to the shower chair. However, the correctional officer left the shower area, leaving the two nursing assistants alone with the resident while he was not			F0604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0604 SS = D	Continued from page 22 handcuffed. During an interview on 7/24/26 at 12:49 p.m., the correctional officer stated he had been informed by the facility that handcuffing the resident was not necessary if the officer briefly stepped away from the room. During an interview on 7/24/26 at 1:49 p.m., director of nursing (DON) stated the resident was to be handcuffed to the bed whenever the guard left the room, staff were to complete skin assessments related to the handcuffs, and the guard would leave the key with nursing staff in case of an emergency. DON stated only the guards applied or removed the handcuffs, and facility staff were not to be in control of the restraint. During an interview on 7/24/26 at 2:34 p.m., administrator stated that R45 was handcuffed whenever the guard stepped away from the room. The guard was required to inform the staff they were stepping away and handed the keys to the nurse. Administrator stated the facility staff were allowed to remove the handcuffs in case of emergency. Facility policy regarding physical restraints was requested, however, none was provided.			F0604			
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,			F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0605 SS = D	Continued from page 23 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or			F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0605 SS = D	Continued from page 24 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from unnecessary psychotropic medications, including failure to ensure as needed (PRN) psychotropic medications had appropriate stop dates for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include:			F0605			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0605 SS = D	Continued from page 25 R20's admission Minimum Data Set (MDS), dated 6/16/26, indicated R20 was cognitively intact and required assistance from staff with activities of daily living (ADLs). R20's diagnoses included emphysema (lung disease), major depression, panic disorder, post-traumatic stress disorder, and anxiety. R20's physician orders, dated 7/8/26, identified R20 had orders for olanzapine (an antipsychotic) 5 milligrams (mg) by mouth every twelve hours PRN for anxiety initiated 7/2/26, trazodone (an antidepressant) 25mg every twenty-four hours PRN for insomnia initiated 7/2/26, and hydroxyzine (a sedating antihistamine/psychotropic) 50 mg every six hours PRN for anxiety initiated 7/2/26. However, R20's olanzapine, trazodone and hydroxyzine orders did not include a stop date, specific duration, or documented prescriber rationale for extending the PRN psychotropic medication beyond 14 days, as required. During an interview on 7/24/26 at 1:04 p.m., registered nurse (RN)-C stated PRN psychotropic medications required an end dated of at least 14 days, the provider could write the order for longer but had to provide a rational. RN-C reviewed R20's physician orders and verified end dates were not indicated on the orders. During an interview on 7/24/26 at 1:06 p.m., director of nursing (DON) stated when PRN psychotropic medication orders were received, the expectation was for the nurses to contact the provider and obtain an end date as required. DON reviewed R20's medications and confirmed there were no end dates for R20's psychotropic medications. The facility's Psychotropic Medication Use policy, revised 5/2025, indicated PRN orders for psychotropic medications would be limited to 14 days unless the physician identified the rational to extend the medication beyond 14 days.			F0605			
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be			F0761			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0761 SS = D	Continued from page 26 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident's (R43) discontinued controlled narcotic medication was not stored with in-use medications in 1 of 3 medication carts. Findings include: During an observation on 7/21/26 at 10:56 a.m., of the South Hall medication cart narcotic cabinet with registered nurse (RN)-A identified three medications identified for R43 who passed away on 7/17/26. R43's-controlled medications remained in the narcotic cabinet with current in use medications. The medications included: Lorazepam (Ativan a controlled medication used for anxiety), 1 blister package card containing 30 0.5 milligram (mg) tablets. Lorazepam liquid in a 25-milliliter bottle with orders 0.25ml by mouth (PO) every (Q) 4 hours (H) scheduled and 0.25ml Q2H as needed (PRN). 24.75 ml remained in the bottle. Hydromorphone (Dilaudid a prescription opioid			F0761			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
F0761 SS = D	Continued from page 27 medication) liquid with orders to administer 1 ml Q4H scheduled, and Q1H PRN. 109ml remained in the bottle. During an interview on 7/21/26 at 11:00 a.m., RN-A identified controlled medications remained stored in the locked narcotic drawer on medication carts until 2 licensed nurses had time to destroy and log them. RN-A reported she was unaware that discontinued controlled medication were not to be stored with in-use medications. During an interview on 7/21/26 at 11:16 a.m., director of nursing (DON) confirmed R34 had passed away in the facility on 7/17/26 and her medications should have been counted, documented in the narcotic log, and removed from the narcotic cabinet on the medication cart, and stored in a secure, double locked, area until 2 licensed nurses were able to destroy them. A policy on management of controlled discontinued medications was requested but not provided.			F0761			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/20/26 through 7/24/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20000	Continued from page 1 reviewed: H54593238C (2679205); H54593239C (2683146); H54593235C (2684261); H54593234C (2988432); H54593240C (1177774). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			20000			
20510	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 2 Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical			20510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20510	Continued from page 2 symptoms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a resident remained free from physical restraints not required to treat a medical symptom when the facility incorporated the use of law enforcement handcuffs into resident's care plan for 1 of 1 resident (R45) reviewed for restraints. Findings include: R45's admission record, printed 7/24/26, indicated R45 admitted to the facility on 7/20/26, and diagnoses included abdominal aortic aneurysm without rupture and diabetes. R45's care plan, initiated 7/21/26, indicated a physical restraint was "deemed necessary" by county policy due to R45's criminal history. The care plan indicated corrections staff would remain in R45's room or observe R45 "at all times". The care plan further indicated R45 would be handcuffed if security left the room, and security staff would place and remove handcuffs for the resident. However, the care plan also indicated staff would place and remove handcuffs PRN (as needed). R45's Informed Consent for Use of Physical Restraints, signed 7/21/26, listed the type of restraint as "handcuffs when not in vision of security guard due to the need for 24-hour supervision related to admitting to hospital and SNF from jail". R45's Order Summary Report, dated 7/24/26, indicated an order "OK to apply handcuffs to resident as needed for safety every shift", with a start date of 7/21/26. However, the order did not identify a medical symptom that warranted the use of the restraint. During an interview on 7/24/26 at 10:47 a.m., anonymous staff A stated there was an inmate in the facility. Staff had been instructed to provide a shower for R45 with two staff present, the guard was to remain in the room and R45 was to be handcuffed to the shower chair. However, the correctional officer left the shower area, leaving the two nursing			20510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20510	Continued from page 3 assistants alone with the resident while he was not handcuffed. During an interview on 7/24/26 at 12:49 p.m., the correctional officer stated he had been informed by the facility that handcuffing the resident was not necessary if the officer briefly stepped away from the room. During an interview on 7/24/26 at 1:49 p.m., director of nursing (DON) stated the resident was to be handcuffed to the bed whenever the guard left the room, staff were to complete skin assessments related to the handcuffs, and the guard would leave the key with nursing staff in case of an emergency. DON stated only the guards applied or removed the handcuffs, and facility staff were not to be in control of the restraint. During an interview on 7/24/26 at 2:34 p.m., administrator stated that R45 was handcuffed whenever the guard stepped away from the room. The guard was required to inform the staff they were stepping away and handed the keys to the nurse. Administrator stated the facility staff were allowed to remove the handcuffs in case of emergency. Facility policy regarding physical restraints was requested, however, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure potential restraint use is identified. Staff education could be completed to identify use of restraints. The information could be shared with the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20510			
20800	Nursing Personnel; Staffing requirements CFR(s): MN Rule 4658.0510 Subp. 1 Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes			20800			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 4 relief duty, weekends, and vacation replacements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents' call lights were responded to timely to meet resident needs for 5 of 6 residents (R4, R6, R13, R20, and R38) reviewed for call light response times. This failure resulted in residents experiencing prolonged wait times for assistance and placed residents at risk for unmet care needs, including toileting, hygiene, and other requests for assistance. Findings include: R4's quarterly Minimum Data Set (MDS), dated 6/4/26, indicated R4 was cognitively intact, and diagnoses included chronic respiratory failure, heart failure, and anxiety disorder. R4 had lower extremity impairment on both sides, used a wheelchair, was dependent on staff for dressing, transfers, and toileting, and was frequently incontinent. During an interview on 7/20/25 at 2:23 p.m., R4 stated she was concerned about long call light times. During an interview on 7/22/26 at 3:56 p.m., nursing assistant (NA)-C stated R4 used her call light frequently and required the assistance of 2 staff with transfers with a mechanical lift. Review of R4's call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 6/24/26 at 12:51 p.m. - response time 44 minutes 6/25/26 at 5:47p.m. - response time 68 minutes 6/25/26 at 8:11 p.m. - response time 61 minutes 6/27/26 at 6:21 p.m. - response time 33 minutes 6/28/26 at 10:37 a.m. - response time 44 minutes 6/28/26 at 6:57 p.m. - response time 57 minutes 6/28/26 at 8:43 p.m. - response time 39 minutes			20800			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 5 6/29/26 at 6:34 a.m. - response time 55 minutes 6/29/26 at 12:49 p.m. - response time 45 minutes 6/29/26 at 3:24 p.m. - response time 33 minutes 6/29/26 at 5:57 p.m. - response time 70 minutes 6/30/26 at 6:29 p.m. - response time 67 minutes 7/1/26 at 5:37 p.m. - response time 49 minutes 7/1/26 at 6:38 p.m. - response time 38 minutes 7/1/26 at 8:30 p.m. - response time 45 minutes 7/2/26 at 6:14 p.m. - response time 37 minutes 7/2/26 at 9:10 p.m. - response time 67 minutes 7/3/26 at 11:28 a.m. - response time 77 minutes 7/3/26 at 2:46 p.m. - response time 39 minutes 7/3/26 at 5:38 p.m. - response time 43 minutes 7/4/26 at 12:26 p.m. - response time 66 minutes 7/4/26 at 6:01 p.m. - response time 47 minutes 7/5/26 at 12:35 p.m. - response time 44 minutes 7/5/26 at 6:08 p.m. - response time 56 minutes 7/5/26 at 8:44 p.m. - response time 53 minutes 7/6/26 at 8:08 p.m. - response time 39 minutes 7/6/26 at 6:25 p.m. - response time 51 minutes 7/6/26 at 7:26 p.m. - response time 40 minutes 7/7/26 at 6:09 p.m. - response time 38 minutes 7/7/26 at 7:45 p.m. - response time 74 minutes 7/8/26 at 7:17 a.m. - response time 46 minutes 7/8/26 at 10:17 a.m. - response time 31 minutes 7/8/26 at 6:52 p.m. - response time 53 minutes 7/8/26 at 9:36 p.m. – response time 43 minutes 7/11/26 at 4:29 p.m. - response time 30 minutes			20800			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 6 7/11/26 at 5:54 p.m. - response time 54 minutes 7/13/26 at 5:10 p.m. - response time 38 minutes 7/14/26 at 12:15 p.m. - response time 30 minutes 7/14/26 at 7:08 p.m. - response time 60 minutes 7/15/26 at 4:50 p.m. - response time 46 minutes 7/15/26 at 6:06 p.m. - response time 63 minutes 7/16/26 at 4:49 p.m. - response time 32 minutes 7/16/26 at 8:08 p.m. - response time 34 minutes 7/17/26 at 6:22 a.m. - response time 36 minutes 7/17/26 at 12:09 p.m. - response time 50 minutes 7/18/26 at 3:37 p.m. - response time 30 minutes 7/18/26 at 4:07 p.m. - response time 39 minutes 7/19/26 at 3:06 p.m. - response time 42 minutes 7/19/26 at 5:58 p.m. - response time 68 minutes 7/20/26 at 6:07 p.m. - response time 67 minutes 7/21/26 at 4:59 p.m. - response time 92 minutes 7/22/26 at 6:39 p.m. - response time 36 minutes R6’s quarterly Minimum Data Set (MDS), dated 6/11/26, indicated R6 was cognitively intact, required staff assistance with toileting, had an indwelling catheter and was incontinent of bowel. R6’s diagnoses included Crohn’s disease (long-term type if inflammatory bowel disease), urinary tract infection, muscle weakness, chronic pain, neuromuscular dysfunction of bladder (lack of bladder control caused by brain, spinal cord or nerve damage), and neurogenic bowel (loss of normal bowel control and function). During an interview on 7/21/26 at 11:09 a.m., R6 stated she had complained several times that the call light was on for up to an hour waiting for staff to assist with incontinent cares. R6 stated she ends up sitting in a bowel movement for extended periods of time resulting in bladder infections.			20800			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 7 Review of R6's call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 6/22/26 at 6:09 p.m. - response time 115 minutes 6/22/26 at 9:04 p.m. – response time 60 minutes 6/25/26 at 6:23 p.m. – response time 39 minutes 6/25/26 at 7:49 p.m. – response time 71 minutes 6/26/26 at 11:11 a.m. – response time 53 minutes 6/26/26 at 8:46 p.m. – response time 85 minutes 6/27/26 at 9:14 p.m. – response time 31 minutes 6/29/26 at 10:24 a.m. – response time 32 minutes 6/29/26 at 7:39 p.m. – response time 80 minutes 7/1/26 at 4:24 p.m. - response time 38 minutes 7/1/26 5:41 p.m. - response time 44 minutes 7/1/26 at 7:23 p.m. - response time 32 minutes 7/2/26 at 12:33 p.m. - response time 47 minutes 7/2/26 at 6:40 p.m. - response time 62 minutes 7/2/26 at 9:16 p.m. - response time 53 minutes 7/3/26 at 6:44 p.m. – response time 69 minutes 7/6/26 at 8:33 a.m. – response time 42 minutes 7/7/26 at 2:45 p.m. – response time 51 minutes 7/7/26 at 8:07 p.m. - response time 36 minutes 7/8/26 at 6:29 p.m. - response time 47 minutes 7/10/26 at 1:25 p.m. - response time 37 minutes 7/10/26 at 5:37 p.m. - response time 50 minutes 7/11/26 at 6:58 p.m. - response time 37 minutes 7/13/26 at 4:49 p.m. - response time 45 minutes 7/13/26 at 9:32 p.m. - response time 32 minutes			20800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 8 7/14/26 at 5:37 p.m. - response time 61 minutes 7/14/26 at 7:11 p.m. - response time 36 minutes 7/14/26 at 8:47 p.m. - response time 37 minutes 7/15/26 at 3:57 p.m. - response time 136 minutes 7/16/26 at 7:39 p.m. - response time 44 minutes 7/18/26 at 9:15 a.m. – response time 48 minutes 7/19/26 at 8:43 p.m. – response time 47 minutes 7/20/26 at 5:26 p.m. - response time 67 minutes R13’s quarterly MDS, dated 4/24/26, indicated R13 was cognitively intact, diagnoses included hip fracture, traumatic brain injury (TBI), and depression. R13 had lower extremity impairment on both sides, used a wheelchair, required assistance with transfers, and was frequently incontinent. On 7/22/26 at 9:38 a.m., R13 stated she was concerned about long call light times. R13 stated, “I’m 41 years old. You don’t want to be incontinent.” Review of R13’s call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 6/21/26 at 11:01 a.m. - response time 34 minutes 6/22/26 at 9:00 p.m. - response time 68 minutes 6/28/26 10:53 a.m. - response time 32 minutes 7/1/26 at 8:14 p.m. - response time 31 minutes 7/2/26 at 7:13 p.m. - response time 56 minutes 7/3/26 at 9:36 p.m. - response time 38 minutes 7/7/26 at 10:29 a.m. - response time 39 minutes 7/13/26 at 6:08 p.m. - response time 62 minutes 7/15/26 at 6:40 p.m. - response time 40 minutes 7/20/26 at 10:39 a.m. - response time 48 minutes			20800			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 9 7/20/26 at 3:37 p.m. - response time 87 minutes During an interview on 7/23/25 at 3:54 p.m., nursing assistant (NA)-C stated call lights showed on the central monitor at the nurses' station and on the scroll boards. NA-C stated the busiest time for call lights was after supper, between 6:00 p.m. to 8:00 p.m. During an interview on 7/24/26 at 10:36 a.m., NA-F stated staff answered call lights in the order they were pushed, provided cares, and then went to the next resident until all call lights were answered. R20's admission MDS, dated 6/16/26, indicated R20 was cognitively intact and required assistance from staff with activities of daily living (ADLs). R20's diagnoses included emphysema (lung disease), major depression, panic disorder, post-traumatic stress disorder, and anxiety. On 7/20/26 at 10:40 a.m., an odor of urine was noted in R20's room, and a bedpan was observed on the floor under R20's bed. R20 stated there were several times the call light was on and R20 had to wait for staff to come for over half an hour. Review of R20's call light logs from 6/21/26-7/22/26, identified multiple call light response times greater than 30 minutes: 7/2/26 at 4:32 p.m. - response time 41 minutes 7/3/26 at 4:33 p.m. - response time 46 minutes 7/4/26 at 6:21 p.m. - response time 56 minutes 7/5/26 at 6:39 a.m. – response time 63 minutes 7/16/26 at 4:29 p.m. – response time 32 minutes R38's care plan, dated 7/14/26, indicated R38 had an alteration in bladder and bowel elimination, with identified interventions of assist of one with toileting needs. R38's diagnoses included weakness, diabetes, edema and peripheral autonomic neuropathy			20800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 10 (damage to peripheral nerves that control involuntary body functions like heart rate, digestion and sweating, common symptom included urinary incontinence. R38's bladder evaluation, dated 7/13/26, indicated R38 had urge incontinence which includes symptoms of strong uncontrolled urgency, frequency of urination, moderate to large amount of urine leakage and enuresis (bedwetting). During an interview on 7/20/26 at 11:41 a.m., R38 stated when the call light was turned on, he waited half an hour or more and has ended up sitting in urine-soaked sheets while waiting for the staff to answer the call light. Review of R38's call light logs from 7/13/26-7/22/26, identified multiple call light response times greater than 30 minutes: 7/13/26 at 5:06 p.m. – response time 41 minutes 7/16/26 at 1:06 a.m. – response time 34 minutes 7/16/26 at 3:40 a.m. - response time 56 minutes 7/16/26 at 2:30 p.m. – response time 48 minutes 7/16/26 at 5:35 p.m. - response time 89 minutes 7/16/26 at 9:31 p.m. - response time 36 minutes 7/17/26 at 5:04 a.m. – response time 40 minutes 7/18/26 at 9:25 a.m. - response time 39 minutes During an interview on 7/24/26 at 10:47 a.m., anonymous staff A stated the call boards in the hallways were broken, and staff could only tell when call lights were on was from the nurses' station. Anonymous A stated there were pagers staff wore that alerted them to call lights, but the director of nursing (DON) got rid of those. Anonymous B stated the call light board in the transitional care unit was not working, the call board by the nurses' desk worked periodically, and call board at the end of the hall was broken, faced the floor and had been that way for a while.			20800			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
20800	Continued from page 11 During an interview on 7/24/26 at 1:25 p.m., registered nurse (RN)-C stated call lights were expected to be answered within 8-10 minutes. During an interview on 7/24/26 at 1:29 p.m., DON stated when staff were in rooms, the staff would not know what call lights were on, so staff were expected to check boards or the screen when they came out of a resident's room. DON stated the staff were expected to look at the call light boards in the hallways or the screen at the nurses' desk. DON stated there had been occasional issues with the call lights not running due to wi-fi issues. DON stated she was not aware one of the boards was facing the floor. During an interview on 7/24/26 at 2:24 p.m., administrator stated they had completed call light audits on the floor, they had waited at the nurses' station for one to go on and watched the screen to see how long it took for the staff to turn them off. Administrator acknowledged they did not run call light logs to review for long call light times unless a resident had complained. The facility's Call Light policy, updated 5/16/23, indicated call lights must relay the call to a staff member or centralized location where staff were working such as the nurses' station, however, the policy did not address the timing for call lights to be answered. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could initiate/update facility policy, and implement policy. Staff education could be completed ensure staff understand policy and expectations. The director of nursing or designee could pull call light reports and complete on-going audits. The information could be shared with the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20800			
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect			21100			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21100	Continued from page 12 against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to maintain the walk-in freezer in a clean and safe condition, as evidenced by a large accumulation of ice on the freezer floor and on stored food boxes, and spilled food items. The facility failed to maintain the dining room resident refrigerator/freezer as evidenced by spilled and undated food items. Additionally, the facility failed to ensure staff completed hand hygiene and wore the appropriate hair coverings in the kitchen. This had the potential to affect all 32 residents residing in the facility. Findings include: During an observation on 07/20/2026 at 9:51 a.m., of the walk-in freezer, a large accumulation of ice was observed on the floor at the end of the shelving on the right side of the freezer. The mound of ice measured approximately 18 inches high with a base measuring approximately 3 feet by 2 feet. A separate chunk of ice measuring approximately 4 inches thick by 6 inches long by 5 inches wide was observed resting on top of a box. Another box stored in the corner had a coating of ice on the top and side. The food items inside the boxes were not observed to be frozen together or covered with ice. During an interview on 07/20/2026 at 9:51 a.m., head cook (HC) stated he had not been at the facility for five days and the ice accumulation was not present the last time he had worked. On 07/20/2026 at 12:50 p.m., the walk-in freezer was observed with regional culinary director (RCD). RCD stated the ice mound should have been taken care of long before this for safety. RCD stated, "Someone could come in and slip, and the food could get affected with the ice on the boxes." He further stated it likely had taken approximately three to four months for the ice accumulation to reach its observed size. During an observation on 7/22/26 at 10:30a.m., dietary aide (DA)-A was observed positioned between the stove and metal table mopping the floor. DA-A had a full beard with no cover in place			21100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21100	Continued from page 13 and his hair pulled back in a tail at the back of his neck with no hair cover. The dietary manager (DM) acknowledged DA-A should have a facial hair cover when in the kitchen and directed DA-A to go and apply one. During an interview on 7/22/26 at 10:35 a.m., DA-A reported he usually applied a facial hair cover when entering the kitchen area, but he had forgotten. During a meal service observation on 7/22/26 at 11:19 a.m., nursing assistant (NA)-D entered the kitchen area with her hair in a long ponytail and no hair net. Additionally, NA-D failed to perform hand hygiene upon entering the kitchen area. NA-D went to the walk-in cooler, entered, and returned carrying a glass of milk. During an interview on 7/22/26 at 11:23 a.m., NA-D reported she was retrieving a glass of milk upon a resident's request. NA-D confirmed she had not applied a hairnet, nor performed hand hygiene prior to entering the kitchen area. NA-D reported she should have applied a hairnet, and washed her hands, or requested dietary staff to retrieve the milk, instead of walking into the kitchen area. The DM observed the incident and stated staff walking into the kitchen was not acceptable practice and had been an ongoing issue with unauthorized staff walking into the kitchen. During an observation on 7/22/26 at 12:15 p.m., with the DM of the resident refrigerator/freezer located in the dining room the freezer compartment contained an approximate 1/2-inch layer of ice on the floor of the freezer. The following opened and undated items were in the freezer: 1.5-quart container of Casey's Carmel Cone Sunday ice cream, and a loaf of opened, undated Artesano Hawaiian bread. The door seal contained a granular black substance and food particles, and food particles were noted on the bottom and shelves to the freezer. The refrigerator section contained the following opened and undated items: an opened carton of "Top the Tator" sour cream dip, four plastic containers of pickles, a paper Culvers bag with a sandwich and fries. The seal of the refrigerator door had a black granular substance in the seal and hinge area of the door. The door frame, shelves, and bottom of the refrigerator contained spilled food particles.			21100			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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	
21100	Continued from page 14 During an interview on 7/22/26 at 11:29 a.m., DM stated the cleaning schedule indicated the refrigerator had last been cleaned on 7/21/26, but it had not been cleaned according to DM's expectations. DM stated food placed in the resident refrigerator was expected to be written on the log posted on the front of the refrigerator, and was to include the date, placed in the refrigerator, name, date the item was opened. The facility's Refrigerators and Freezers policy, revised 12/2014, indicated supervisors would inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs, and manufacturer maintenance guidelines would be scheduled and followed. The facility's Food Brought by Family/Visitors policy, revised October 2017, indicated food brought by family or visitors and left for the resident to consume later was to be labeled and stored in a manner distinguishable from facility-prepared food. Non-perishable foods must be stored in re-sealable containers with tight-fitting lids. Perishable foods must be stored in re-sealable containers with tight fitting lids in a refrigerator. Containers must be labeled with the resident's name, the item, and the "use by" date. Nursing staff will discard perishable foods on or before the "use by" date. The nursing and/food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger. SUGGESTED METHOD OF CORRECTION: The administrator, dietary manager, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, dietary manager, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21)		21100				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21100	Continued from page 15 days			21100			
21380	Infection Control; Direction of Program CFR(s): MN Rule 4658.0800 Subp. 2 Subp. 2. Direction of program. A nursing home must assign one person, either a registered nurse or a physician, the responsibility of directing infection control activities in the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) who was also the director of nursing (DON) had appropriate oversight of the infection control (IC) program that included employee surveillance of all employees. This had the potential to affect all 32 residents. Findings include: Review of facility infection control surveillance documents identified the infection preventionist (IP) managed resident illness surveillance, which was included in the infection control surveillance documentation. However, no employee surveillance was included in the infection control surveillance documentation. During an interview on 7/22/26 at 10:23 a.m., the director of nursing/infection preventionist (DON/IP) stated she had nothing to do with tracking or managing employee illness. DON/IP stated employee illness was tracked and managed by the human resources (HR)/scheduling coordinator. The DON/IP stated when an employee called in sick, the scheduling coordinator received the call and tracked their illness by asking the appropriate questions per policy and procedure. The DON/IP reported employee illnesses (call-ins) were discussed during the morning meeting which allowed nursing to add in any suspected correlation between employee illness and resident illness. The DON/IP identified she did not maintain documentation of the morning meetings. During an interview on 7/22/26 at 2:32 p.m., the staffing coordinator (SC) stated when a staff person called-in ill, they were to call both the facility and the staffing phone to notify the department head			21380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21380	Continued from page 16 which staff were calling in and administration. SC reported she primarily delt with nursing staff and when she received a call-in, she attempted to find a replacement. SC identified the forms filled out for staff call-ins were kept in the scheduling binder in her office. SC stated she was not responsible for activity, or culinary staff and managers of those departments managed their own staff call-ins. Review of the forms filled out for staff call-ins indicated the following: -Nursing assistant (NA)-E had called-in on 4/22/26 with reported symptoms of diarrhea beginning 4/20/26 through 4/22/26. NA-E returned to work on 4/25/26, but there was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure NA-E was safe to return to work, or if NA-E had been prohibited from work for an appropriate amount of time. NA-E's time punches were requested but not provided. -NA-C left her shift on 4/5/26 with complaints of nausea and returned to work on 4/19/26. There was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure staff were safe to return to work, or if NA-C had been prohibited from work for an appropriate amount of time. NA-C's time punches were requested but not provided. -Cook-A called-in with vomiting on 5/3/26, reported symptoms resolved on 5/4/26 and returned to her shift in dietary on 5/5/26. There was no indication if the facility had followed infection control standards for criteria in-order to ensure cook-A was safe to return to work, or if cook-A had been prohibited from work for an appropriate amount of time. Cook-A's time punches identified she was off 5/3/26-5/4/26 and returned on 5/5/26. -Dietary Aid (DA)-A called-in on 6/30/26 with complaints of nausea, no additional data was provided and review of DA-A's timecard identified he returned to his shift in the dietary department the next day, on 7/1/26. There was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure DA-A was safe to return to work, or if DA-A had been prohibited from work for an appropriate			21380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21380	Continued from page 17 amount of time. During an interview on 7/22/26 at 4:15 p.m., with the dietary manager (DM) reviewed timecards for the two dietary staff that had call-in with GI symptoms and identified he had followed the MN policy posted in the kitchen which listed an employee must wait 24 hours from their last symptom before returning to work. DM stated cook-A had started her shift on 5/5/26 at 5:00 a.m. which was not within the required time from her last symptom. DM also reported he had been out on leave from 6/15/26 through 7/21/26 and did not know who was overseeing the monitoring of illness for dietary department when he was out on leave, but he assumed someone had. The Infection Preventionist job description identified the IP was responsible to evaluate practice in culinary, laundry, housekeeping, maintenance, and nursing departments to ensure consistency with recommended infection control standards. The IP conducts ongoing infection surveillance, compiles and analyzes data, and prepares reports for presentation to the Infection Prevention and Control Oversight Committee. The facility's Infection Prevention and Control Program policy, dated 4/26/26, indicated it was comprehensive and addressed detection, prevention, and control of infections among residents and personnel. The infection prevention and control program is coordinated and overseen by the IP. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Surveillance tools are used for recognizing the occurrence of infection, recording their number and frequency, detecting outbreaks, monitoring employee infections, and detecting unusual pathogens with infection control implications. The major elements of the program included coordination/oversight, surveillance, outbreak management, prevention of infection, and employee health. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could review/update infection control policy and procedures and provide education to all staff to ensure compliance. The director of nursing or designee (s) could develop a system to conduct random audits to ensure appropriate surveillance is			21380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21380	Continued from page 18 completed, and a system to monitor infection control logs to ensure trends are identified.			21380			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days						
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from unnecessary psychotropic medications, including failure to ensure as needed (PRN) psychotropic medications had appropriate stop dates for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: R20's admission Minimum Data Set (MDS), dated 6/16/26, indicated R20 was cognitively intact and required assistance from staff with activities of daily			21535			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21535	Continued from page 19 living (ADLs). R20's diagnoses included emphysema (lung disease), major depression, panic disorder, post-traumatic stress disorder, and anxiety. R20's physician orders, dated 7/8/26, identified R20 had orders for olanzapine 5 milligrams (mg) by mouth every twelve hours PRN for anxiety initiated 7/2/26, trazodone 25mg every twenty-four hours PRN for insomnia initiated 7/2/26, and hydroxyzine 50 mg every six hours PRN for anxiety initiated 7/2/26. However, R20's olanzapine, trazodone and hydroxyzine orders did not include a stop date, specific duration, or documented prescriber rationale for extending the PRN psychotropic medication beyond 14 days, as required. During an interview on 7/24/26 at 1:04 p.m., registered nurse (RN)-C stated PRN psychotropic medications required an end dated of at least 14 days, the provider could write the order for longer but had to provide a rational. RN-C reviewed R20's physician orders and verified end dates were not indicated on the orders. During an interview on 7/24/26 at 1:06 p.m., director of nursing (DON) stated when PRN psychotropic medication orders were received, the expectation was for the nurses to contact the provider and obtain an end date as required. DON reviewed R20's medications and confirmed there were no end dates for R20's psychotropic medications. The facility's Psychotropic Medication Use policy, revised 5/2025, indicated PRN orders for psychotropic medications would be limited to 14 days unless the physician identified the rational to extend the medication beyond 14 days. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist could develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. The director of nursing (DON) or designee and the consulting pharmacist could educate physicians and staff on the importance of ensuring medication ordered are appropriate for each resident's use. Audits could be			21535			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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	
21535	Continued from page 20 developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		21535				
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed and orders obtained for all medications kept at bedside for 3 of 3 residents (R1, R13, R30) observed with medications at their bedside. Findings include: R1's significant change Minimum Data Set (MDS), dated 6/23/26, indicated R1 was cognitively intact and required assistance with activities of daily living. R1's diagnoses included respiratory failure, chronic pain, anxiety, and asthma. R1's Order Summary Report, printed 7/27/26, indicated R1 had an order for Ventolin HFA Inhalation Aerosol Solution (short acting inhaler, relaxes tight muscles in the airway) 108 micrograms/actuation (Mcg/Act) 2 puffs inhale every four hours as needed for shortness of breath. The summary report also indicated R1 had an order dated 1/28/26 for okay to self-administer inhalers at bedside after set-up pending nursing assessment of self-administration. R1's Self Administration of Medication (SAM) Evaluation, dated 6/23/26, indicated per staff		21565				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21565	Continued from page 21 resident no longer self-administered any medications or creams. "She used to but no longer does self-administer nor does she request to do so". During an observation on 7/22/26 at 3:02 p.m., R1's Ventolin inhaler was observed on the overbed table next to R1's bed, within reach of R1. During an observation on 7/23/26 at 8:29 a.m., R1's inhaler was observed on top of overbed table next to R1's bed. During an interview on 7/23/2026 1:47 p.m., registered nurse (RN)-A stated R1 had an inhaler but it was no longer kept at her bedside. RN-A stated the nurse manager or the director of nursing (DON) completed the self-administration of medications assessments. During an interview on 7/24/26 at 1:04 p.m., RN-C stated R1 needed to demonstrate how to use the inhaler correctly and verbalize when to use the inhaler. RN-C reviewed R1's assessment and verified RN-C's name was on the assessment as having completed the assessment for R1. R13's quarterly MDS, dated 4/24/26, indicated R13 was cognitively intact, and diagnoses included traumatic brain injury (TBI), diabetes, and asthma. On 7/20/26 at 9:38 a.m., a medication cup with 9 tablets/capsules was observed on R13's bedside table. R13 stated she had just woken up and found the medication left at her bedside. During an observation on 7/21/26 at 9:34 a.m., a medication cup with 8.5 tablets/capsules was observed on R13's bedside table. R13 was not in the room at the time. On 7/22/26 at 9:25 a.m., a medication cup with tablets/capsules was observed on R13's bedside table. R13 stated medications had been left at bedside for at least 6 months. R13's Order Summary Report, dated 7/8/26,			21565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21565	Continued from page 22 indicated R13 had an order dated 5/11/26 for may self-administer medication after nursing setup. R13’s SAM Evaluation, dated 5/13/26, indicated R13 was safe to self-administer medication after nursing set up, and inhalers and lozenges kept at bedside. R13’s SAM Evaluation, dated 5/25/26, indicated R13 was able to keep inhaler and lozenges at bedside and self-administer inhalers as ordered, and was able to self-apply lotions and ointments after nursing set up. The evaluation further indicated, “All other medications will be set up and administered by nursing as there have been multiple events of resident forgetting to take medications after they area [sic] set up and left with resident, resulting in missed doses”. However, R13’s electronic health record (EHR) lacked evidence the 5/25/26 SAM evaluation results had been communicated to the provider. Additionally, the EHR lacked evidence R13’s orders and care plan had been updated to reflect the updated evaluation findings. R13’s Medication Administration Record (MAR), dated July 2026, indicated “ok to leave tizanidine and Lyrica at bedside”, with a start date of 7/14/26. However, no other medications were ordered as okay to leave at bedside. During an interview on 7/22/26 at 9:44 a.m., RN-B stated he had set up R13’s medications that day. RN-B stated he left the medications at the bedside for R13 as allowed per provider orders. R30’s quarterly MDS, dated 7/1/26, indicated R30 was cognitively intact and diagnoses included hepatic encephalopathy (a worsening of brain function when a damaged liver can no longer remove toxic substances from the blood), heart failure, and diabetes. R30’s SAM Evaluation, dated 4/21/26, indicated R30 was not reliably safe to self-administer medications. Additionally, the evaluation did not indicate that R30 was able to keep any medications at bedside.			21565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21565	Continued from page 23 On 7/21/26 at 10:38 a.m., fluticasone propionate nasal spray was observed at R30’s bedside. R30 stated she normally self-administered the nasal spray. R30’s MAR, dated July 2026, indicated R30 had an order for Fluticasone Propionate nasal suspension 50 mcg/act 2 spray in each nostril two times a day for allergic rhinitis. No orders for self-administration or medications at bedside were indicated on the MAR. During an interview on 7/24/26 at 11:12 a.m., director of nursing (DON) verified R13’s SAM evaluation indicated she was not safe to self-administer medications. The facility’s Self-Administration of Medications policy, dated 2/2024, indicated the interdisciplinary team (IDT) assesses each resident’s cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident’s medications. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days			21565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident's (R43) discontinued controlled narcotic medication was not stored with in-use medications in 1 of 3 medication carts. Findings include: During an observation on 7/21/26 at 10:56 a.m., of the South Hall medication cart narcotic cabinet with registered nurse (RN)-A identified three medications identified for R43 who passed away on 7/17/26. R43's-controlled medications remained in the narcotic cabinet with current in use medications. The medications included: Lorazepam (Ativan a controlled medication used for anxiety), 1 blister package card containing 30 0.5 milligram (mg) tablets. Lorazepam liquid in a 25-milliliter bottle with orders 0.25ml by mouth (PO) every (Q) 4 hours (H) scheduled and 0.25ml Q2H as needed (PRN). 24.75 ml remained in the bottle. Hydromorphone (Dilaudid a prescription opioid medication) liquid with orders to administer 1 ml Q4H scheduled, and Q1H PRN. 109ml remained in the bottle. During an interview on 7/21/26 at 11:00 a.m., RN-A identified controlled medications remained stored in the locked narcotic drawer on medication carts until 2 licensed nurses had time to destroy and log them. RN-A reported she was unaware that discontinued controlled medication were not to be stored with in-use medications. During an interview on 7/21/26 at 11:16 a.m., director of nursing (DON) confirmed R34 had passed away in the facility on 7/17/26 and her medications			21610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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	
21610	Continued from page 25 should have been counted, documented in the narcotic log, and removed from the narcotic cabinet on the medication cart, and stored in a secure, double locked, area until 2 licensed nurses were able to destroy them. A policy on management of controlled discontinued medications was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		21610				
21810	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide reasonable accommodation of needs and preferences for 1 of 1 resident (R28) reviewed for environmental scents. Findings include: R28's quarterly Minimum Data Set (MDS), dated 5/18/26, indicated R28 was cognitively intact, and diagnoses included diabetes, heart failure, asthma, and allergies. R28's care plan, last revised 5/21/26, indicated R28 had multiple allergies and intolerances, many allergies to different scents, and required assist of one with bathing.		21810				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21810	Continued from page 26 During an interview on 7/20/26 at 2:30 p.m., R28 stated she does not participate in activities due to allergies and used an N-95 mask to provide scent blockage. R28 stated because of the chemicals and fragrances used in the shower room, she did not get her scheduled shower. R28 stated she has gone up to three weeks a couple of times without showers. R28 stated that one time staff had her use the shower room before any other residents and she showered without any issues. During an interview on 7/23/26 at 2:12 p.m., nursing assistant (NA)-D stated R28 was very sensitive to smells and wore a mask a lot. During an interview on 7/23/26 at 3:49 p.m., NA-E stated R28 required supervision with showers, and R28 was very sensitive to scents or odors. During an interview on 7/24/26 at 10:31 a.m., environmental service (ES) stated the facility took residents' sensitivity to chemical smells seriously. ES stated R28 had a sign on her door that it is a scent-free room due to R28's allergies, and staff followed the posted restrictions. ES stated the employee handbook instructed staff to not wear strong perfume or extra aroma items because it showed respect for the residents. During an interview on 7/24/26 at 2:46 p.m., registered nurse manager (RN)-C stated the facility had made arrangements one time for R28 to be offered the first shower of the day. RN-C stated R28 has not requested the first shower of the day since. The facility's Employee Handbook 2026 indicated scents must be limited and barely perceptible, in recognition of resident sensitivities and allergies. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure reasonable accommodation of all residents specific needs and preferences. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.			21810			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT WINSTED LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH , WINSTED, Minnesota, 55395			
(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
21810	Continued from page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days			21810			