Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 26, 2023

Administrator
The Gardens At Winsted LLC
551 Fourth Street North
Winsted, MN 55395-0750

RE: CCN: 245459
Cycle Start Date: April 6, 2023

Dear Administrator:

On May 26, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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Electronically delivered

April 25, 2023

Administrator
The Gardens At Winsted LLC
551 Fourth Street North
Winsted, MN 55395-0750

RE: CCN: 245459
Cycle Start Date: April 6, 2023

Dear Administrator:

On April 6, 2023, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 July 6, 2023, (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 October 6, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

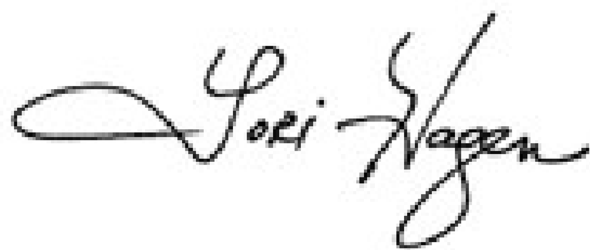
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,



Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 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
F 000	INITIAL COMMENTS On 04/02/23 to 04/06/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H54599867C (MN83758), H54599868C (MN85030) AND The following complaint was reviewed: H54599869C (MN91449) with a deficiency issued at F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		5/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/04/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

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F 580	Continued From page 2 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to notify the medical provider and resident representatives of weight loss for 1 of 1 resident (R25) reviewed for notification of change. Findings include: R25's admission Minimum Data Set (MDS) dated 3/14/23, identified R25 had severe cognitive impairment and was not able to clearly communicate his needs and wishes. Further, R25 required extensive assistance for his activities of daily living (ADL's) and had several medical diagnoses including expressive language disorder (communication disorder in which there are difficulties with verbal and written expression), dysphagia (difficulty in swallowing food or liquid), chronic kidney disease, stage 4 (severe) (gradual loss of kidney function), dietary calcium deficiency, retention of urine, hypokalemia (low levels of potassium), hypomagnesemia (low levels of magnesium), essential hypertension (high blood pressure) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). R25's care plan dated 3/7/23, identified R25 required additional monitoring due to current nutritional status at risk due to mechanically altered diet and directed staff to obtain weight monthly, obtain/review labs per MD (medical	F 580	The medical provider and resident representatives were notified of R25s weight loss. All residents have the potential to be affected if this requirement is not met. All GAW staff have been re-educated to the requirement/regulation. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party.	

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F 580	Continued From page 3	F 580		

doctor) order and record nutritional intakes per facility protocol.

R25's weights documented on the admission orders and Medication Administration Record, identified the following:
-3/7/23: 204.2 (hospital discharge weight per discharge orders)
-3/7/23: 206.5 at facility
-3/26/23: 186.5 (9.69 % weight loss)
-4/2/23: 183 (1.88% weight loss)
Total of 11.38% weight loss in 27 days

R25's medical record lacked evidence the medical provider and family were notified of the weight loss.

During interview on 4/2/23, at 3:50 p.m. family member (FM)-A stated the facility does not notify her of changes right away and they wait to notify her until she comes to visit.

During interview on 4/2/23, at 4:29 p.m. FM-B stated the facility did not notify her of R25's weight loss and she had to ask staff when she visited what R25's weight was. Staff informed her that his weight was "183" FM-B stated, "he has lost a lot."

During interview on 4/5/23, at 11:50 p.m. registered nurse (RN)-B stated when a provider or nurse practitioner comes to the facility for rounds/visits, facility gives them the resident's face sheet. RN-B stated the provider has access to PCC (point click care the electronic medical record) to review resident's information and when at facility if the provider has additional questions on a resident, they will find staff. RN-B stated weights are documented by the nursing

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F 580	Continued From page 4 assistants (NA) and put on a weight board that is behind the nurse's desk. RN-B stated the NA's would let the nurses know if there was a significant change in weight and then the nurses would review, ask for a reweigh and if the second weight continued to be off, they would then obtain vital signs, listen to lungs sounds, check for edema, and would update the provider via phone call or physician portal. RN-B stated the notification to providers would be documented in the resident's progress notes. RN-B also stated for notification to family members, she would look at resident's contact list and call whoever she could get a hold of first. RN-B stated she would notify the provider first and once a plan was developed then she would notify family as she does not call family before because they may have questions that she would not be able to answer. RN-B was not aware of any weight loss for R25. During interview on 4/5/23, at 4:00 p.m. director of nursing (DON) stated the registered dietician (RD) monitors resident weights the most and depending on which resident, the DON would also review weights if it is triggered on the dashboard. Significant weight loss shows up in red to alert staff. DON stated if she noticed an abnormal weight, she would notify the provider when the nurse practitioner (NP) is on site. DON stated once the registered dietician (RD) reviews weights, she would send out an email with a recommendation and then a referral would be sent to provider via the physician portal. DON stated if the provider would have been notified about R25's weight loss there would have been documentation in the progress notes. DON stated the provider also has access to PCC to review resident's chart. DON stated the provider had not	F 580		

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F 580	Continued From page 5 been notified of weight loss for R25 and she would be sending a message via the portal immediately. During interview on 4/6/23, at 8:38 a.m. nurse practitioner (NP) stated the facility had not notified her of R25's weight loss and she was also not notified while she was on site during rounds. NP stated if she would have been notified of weight loss she would have reviewed, and would have placed a referral to a RD, add a house nutritional supplement to make sure that resident was receiving enough calories, and order more frequent weights for monitoring. During interview on 4/6/23, at 9:05 a.m. RD stated when she was reviewing weights on 4/2/23, she had reached out to the facility for a reweigh on R25. RD stated that reweigh was done but was not able to give the weight that was obtained or that she had acted upon it. RD stated that she is following up on R25's weight currently and is reassessing R25 and will probably add on a supplement. RD stated the registered dieticians review and monitor resident's weight but that there had been a glitch due to the other RD being on maternity leave. RD stated that weights are also reviewed at morning meetings. A facility policy was requested for notification of change, however, was not received.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		5/24/23

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F 583	Continued From page 6 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff, and visitors to view for 1 of 1 resident (R192) observed to have private information visible on an open computer screen in a common area.	F 583	R192s confidential information was made not readily available for all residents, staff, and visitors to view. All residents have the potential to be affected if this requirement is not met. All GAW staff have been re-educated to	

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F 583	Continued From page 7 Findings include: R192's admission Minimum Data Set (MDS) dated 3/23/23, indicated R192 was cognitively intact and was able to clearly communicate her needs and wishes. The MDS indicated R192 required limited to extensive assistance with all activities of daily living (ADL). During continuous observation on 4/4/23, from 3:23 p.m. to 3:33 pm R192's picture and medications were displayed on an open computer screen that was left unattended on the nurse's medication cart in the common area by nurse's station. At 3:23 p.m. computer screen, on med cart, was open with R192's personal information visible on screen. At 3:24 p.m. another resident and her husband walked past the med cart and looked in the direction of the open computer screen where R192's personal information was present on screen. At 3:25 p.m. a visitor (a reporter from the local newspaper) walked past the med cart and looked in the direction of the open computer screen where R192's personal information was present on screen. At 3:29 p.m. a staff member walked by med cart and did not lock the computer screen leaving R192's personal information displayed on screen. At 3:30 p.m. another staff member walked by the med cart and did not lock the computer screen leaving R192's personal information displayed on screen. At 3:33 p.m. licensed practical nurse (LPN)-A walked past the med cart, saw that the computer screen was open to R192's personal information, stopped, backed up and locked the screen so that R192's personal information was not displayed on screen. During interview on 4/6/23, at 10:36 a.m. nursing	F 583	the requirement/regulation. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party.	

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F 583	Continued From page 8 assistant (NA)-D stated when leaving the medication cart she makes sure the screen is locked with no resident information visible. NA-D stated it is important to lock screen so that no other residents, family members or visitors can see any resident's information. During interview on 4/6/23, at 12:51 p.m. director of nursing (DON) stated that staff need to make sure computer screens are closed or locked before walking away from medication cart. DON stated it is important to lock screens because of HIPAA [Health Insurance Portability and Accountability Act]. The facility's "Notice of Privacy Practices" policy dated 7/1/15 indicated "we are required by law to maintain the privacy and security of your protected health information." The "HIPAA and Confidentiality of Client Matters" policy, no date on policy, indicated "We take our clients' privacy and confidentiality very seriously. Our professional ethics require that each employee maintain the highest degree of confidentiality when handling our resident's and tenant's matters. The Resident Bill of Rights and the HIPAA Privacy and Security Standards guarantee confidential treatment of clients' individual health information."	F 583		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		5/24/23

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F 686	Continued From page 9 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement pressure ulcer interventions for 1 of 1 resident (R25) identified at risk for pressure ulcers. Findings include: R25's admission Minimum Data Set (MDS) dated 3/14/23, identified severe cognitive impairment with diagnosis including aphasia (difficulty speaking), dysphagia (difficulty swallowing), a stroke, kidney failure, low blood potassium, low blood sodium, and heart failure. R25 required extensive assistance with mobility and did not have any pressure ulcers. R25's care plan dated 3/7/23, identified alteration in skin integrity and directed staff to apply protector on left heel when resident was in bed, monitor skin integrity daily during cares with weekly inspection by nurse, treatment to open areas per order, turn and reposition or reminders to offload q (every) 2-3 hours and PRN (as needed), pressure redistribution mattress to bed, pressure redistribution cushion to w/c (wheel chair) and chair, weekly measurements and assessment of wound, monitor for skin breakdown for signs/symptoms of infection and report signs/symptoms to MD (medical doctor) or	F 686	Pressure Ulcer intervention, heel protectors, were placed onto R25's left heel. Pressure Ulcer interventions were added to CNA care sheets. All residents with pressure ulcers have the ability to be affected if this requirement is not met. All GAW staff have been re-educated to the requirement/regulation. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party.	

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PA-C (physician assistant), and document on skin condition and keep MD or PA-C informed of changes.

R25's Clinical Nutrition Evaluation, dated 3/16/23, and was completed by facility's registered dietician (RD) indicated: Supplements: recommend Pro Stat at 30 cc QD d/t low alb (low albumin). Labs: alb = 2.5 (normal albumin level is 3.5 to 5.0 - albumin is one of several proteins made in the liver. The body needs these proteins to fight infections and to perform other functions including wound healing.)

R25's progress notes identified a wound on left heel first developed on 3/31/23 with 4/3/23 being the first wound care appointment. R25's Initial progress note, from Integrated Wound Care, dated 4/3/23 indicated, "Needing assessment and management of unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) pressure ulcer to left heel. Per facility nurse edges are lifting. Current dressing orders are for betadine. No pain to area. Using heel protectors. Therapy wondering about weight bearing status with wound.
Wound: #1 left Heel Pressure Ulcer: Unstageable
Measures 1 cm (centimeter) x 1.5 cm x 0.2 cm
Exudate: Small Serosanguinous (containing blood and serum)
Odor: None
Tissue Type: 100% Necrotic (dead tissue)
Periwound: (+) blanching erythema (redness)
Note: Able to remove entire eschar (slough or piece of dead tissue that sheds off from the surface of the skin after an injury) cap, revealing wound measurements above. Still 100% necrotic

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F 686	Continued From page 11 tissue. Treatment Recommendations: Cleanse gently with wound cleanser. Pat dry. Paint with betadine. Allow to dry. Cover with silicone foam border dressing whenever possible. Change 3 x per day and PRN (as needed). Pressure Relief/Offloading: Facility pressure ulcer prevention protocol. Heel offloading per facility protocol. Turn and reposition per facility protocol. Misc order: Diabetes control Plan of care: Plan of care discussed with facility staff. Plan of care discussed with patient. Paper copy of verbal order received, from wound care NP, on 4/4/23 was reviewed and included, "Wound left heel: Cleanse gently with wound cleanser. Pat dry. Paint with betadine. Allow to dry. Cover with silicone foam border dressing. Change 3 x weekly every day shift every Mon, Wed, Fri for pressure ulcer." R25's progress notes, from 3/7/23 to 4/6/23, were reviewed with no documentation in regards to heel protectors in general and/or documentation that R25 attempted to kick heel protectors off once applied. During observation on 4/2/23, at 2:12 p.m. R25 was lying in bed and was sliding his heels back and forth against the bed, rubbing the pressure ulcer area on bed. Heel protectors were noted sitting in a chair. During observation on 4/3/23, at 2:41 p.m. R25 was lying in bed with no heel protector on left heel. During observation on 4/4/23, at 7:41 a.m. R25 was sitting up in wheelchair drinking a cup of	F 686		

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soda with no heel protector on left heel. R25 had a gripper sock on foot and heel of foot was sitting flat on the floor. At 12:43 p.m. R25 was sitting up in wheelchair in his room with again with heel resting on floor. R25 was sliding his feet back and forth against the floor. At 3:13 p.m. R25 was lying in bed with no heel protector on left heel with heel laying flat on the bed.

During observation and interview on 4/5/23, at 10:14 a.m. registered nurse (RN)-B performed wound care on R25's left heel. When taking R25's sock off left foot, there was no dressing present on wound with wound being open to air and had sock up against skin/wound surface. RN-B stated wound was, "pale pink with a brown tinge. Surrounding tissue was a blanchable pink." During cleaning of wound with wound cleanser, R25 stated, "owe" with RN-B asking R25 if he was experiencing pain R25 stated, "yes." RN-B continued cleansing with wound cleanser, applied betadine to area and applied an Allevyn dressing. RN-B stated that dressing is changed three times weekly. RN-B initialed and dated dressing.

During observation on 4/6/236, at 1:14 p.m. R25 was lying in bed with no heel protectors on. At 1:50 p.m. R25 continued to be lying in bed and had heel protector on left leg turned backwards and it was up on his shin. Multiple staff walked past R25's room, turning their heads and looking in room at R25, and continued to walk past without repositioning heel protector. At 1:54 p.m. when DON came to room and DON stated to R25, "well this isn't going to do you any good," referring to the heel protectors being turned around and up on R25's shin. DON repositioned heel protector to left heel.

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During interview on 4/2/23, at 4:29 p.m. family member (FM)-B stated she was concerned about the new wound on R25's heel that he did not have before. FM-B stated R25 lays in bed a lot and when she comes to visit there is no pillow under his feet or heel protector on to suspend feet off bed. FM-B had repeatedly asked staff to apply heel protectors with staff stating to FM-B that they would put heel protectors on but that R25 kicks them right off. FM-B has not witnessed R25 kicking off heel protectors while visiting.

During interview on 4/5/23, at 11:50 a.m. RN-B stated heel protectors were to always be on R25's left heel.

During interview on 4/6/23, at 8:38 a.m. nurse practitioner (NP) stated, the facility had not notified her of R25's recent weight loss of over eleven percent, which could have contributed to the pressure ulcer on his heel along with other risk factors of lack of exercise and diabetes. The NP stated, if aware of the significant weight loss, they would have assessed and ordered a supplement.

During interview on 4/6/23, at 12:51 p.m. DON stated R25 was to have, "heel protectors on when in bed and on when he was not wearing shoes so that his heel is not sitting on floor."

The facility Skin Assessment & Wound Management policy dated 2/10/23 indicated "Provide guidelines for assessing and managing wounds. 1. A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2. Implement appropriate preventative skin measures. 3. Tissue Tolerance Evaluation is completed on

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F 686	Continued From page 14 admission, annually, and upon significant change. 4. Staff will perform routine skin assessments (with daily care). 5. Nurses are to be notified if skin changes are identified. 6. A weekly skin inspection will be completed by licensed staff. Pressure Wounds- New Skin Problem: When a pressure ulcer is identified, the following actions will be taken: 1. Notify MD/Treatment Ordered. 2. Notify resident representative. 3. Complete education with resident/resident representative including risks & benefits. 4. Initiate Weekly Wound Evaluation. 5. Notify Nurse Manager/Wound Nurse. 6. Referral to dietary, if appropriate. 7. Referral to therapies, if appropriate. 8. Update Care Plan. 9. Update resident care lists. 10. Update Care Plan to identify risks for skin breakdown.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		5/24/23

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F 690	Continued From page 15 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents received appropriate ongoing catheter care that adhered to professional standards of practice and infection prevention for 3 of 3 residents (R33, R22, R25) who were reviewed for indwelling urinary catheter use. Findings include: R33's significant change Minimum Data Set (MDS) dated 2/17/23, indicated he had moderately impaired cognition, an indwelling urinary catheter and required extensive assist of 2 with toileting and personal hygiene. R33's Waconia Ridgeview Hospital Interagency Referral Form dated 2/10/23, indicated an indwelling urethral catheter for urinary retention was placed during his inpatient hospitalization prior to returning to the facility on 2/10/23.	F 690	R33, R22, and R25 received appropriate catheter care that adhered to professional standards. R33, R22 and R25s care plans were reviewed to ensure they included information on the size of catheter and interventions regarding the daily cares of the catheter. Orders to monitor R33s catheter were entered. R33, R22, R25 cather orders were reviewed to ensure they included a diagnosis for use of catheter, size of catheter, frequency of changes and an order for when to replace the catheter bag and leg bag if applicable. All appropriate GAW staff were educated and competencies were completed on catheter cares. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly	

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R33's care plan dated 2/16/23, indicated the presence of an indwelling catheter and directed staff to, "change catheter per physician order and when needed, to position catheter bag and tubing below the level of the bladder, to monitor and document intake and output as per facility policy, to monitor and document pain and discomfort due to catheter and to monitor and report to MD [Medical Doctor] any signs or symptoms of urinary tract infection." The care plan did not include information on the size of the catheter or interventions regarding the daily cares of the catheter.

R33's February Treatment Administration record (TAR) lacked any documentation indicating monitoring had been done from readmit on 2/10/23 to 2/19/23. Documentation was present for monitoring of the catheter from 2/20/23 to 2/22/23. There was no documentation for monitoring of the catheter from 2/23/23 to 2/28/23.

R33's Foley Catheter Evaluation dated 2/17/23, indicated, "Waiting on Urology appointment and appropriate DX [diagnosis] for indwelling catheter. Multiple attempts to remove at hospital. No trauma noted from catheter."

R33's signed provider order dated 2/17/23, indicated, "Indwelling Foley cath [catheter] placed-voiding trial in 1 week. OK for Indwelling cath, cath cares per facility policy. Also to reinsert if unable to void in 8 hours, or PVR [Post Void Residual] was greater than 250 CCs [cubic centimeters] x 3." The order did not include a diagnosis for use, size of catheter or frequency of changes.

F 690

thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence.

Director of Nursing or designee is responsible party.

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A facility Nurses Communication form sent with R33 to his Urology consult visit dated 2/21/23 indicated his catheter was removed at 5:30 a.m. that morning per order and no urinary output was noted since. The provider responded with orders to replace the catheter and return in a month. The orders did not include a diagnosis for use, size of catheter or frequency of changes.

R33's progress note dated 3/7/23, indicated a transfer back and re-admission to Ridgeview hospital in Waconia related to staff inability to irrigate his catheter and blood noted after catheter replacement. The note did not specify the catheter type, size or technique used to replace.

R33's MDS entry tracking record indicated he returned to the facility on 3/15/23.

R33's hospital discharge summary dated 3/15/23, indicated urology was consulted regarding a Foley catheter and recommended to discharge with the indwelling urethral catheter which was placed while inpatient on 3/7/23. R33's discharge summary indicated he had diagnosis of severe Sepsis (a life-threatening complication of an infection) due to Enterococcus and Escherichia Coli (E-coli) bacteria secondary to complicated urinary tract infection and would require a peripherally inserted central catheter (PICC) for antibiotic administration.

R33's hospital discharge orders to the facility dated 3/15/23, indicated, "Foley catheter care." The hospital discharge orders did not specify a diagnosis for use, size of catheter or frequency of catheter changes.

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R33's Foley Catheter Care Evaluation dated 3/22/23, indicated "Resident being followed by urology at current. Voiding trial attempted at last follow-up appointment on 2/21/23. Resident failed voiding trial and new catheter was placed by urology. Resident to follow-up with neurology and urology. Resident recently hospitalized due to E-coli bacteremia."

R33's facility Order Summary Report dated 4/2/23, lacked any orders indicating a diagnosis for use, the size of the catheter, the frequency of catheter changes or when to replace the catheter bed and leg bags.

R33's March 2023 Treatment Administration record lacked documentation of catheter cares or monitoring.

During observation on 4/3/23, at 9:33 a.m. R33 was noted to be in his room, up and dressed with his catheter leg bag secured to his left leg and in his wheelchair. R33's catheter bed bag was noted to be laying on top of a plastic 3-drawer storage tote in his bathroom with whom he shared with another resident. The bed bag was empty and not covered.

During observation on 4/4/23, at 7:17 a.m. R33 was noted to be up in his wheelchair, dressed with his leg bag secured to his left leg and watching television. R33's catheter bed bag was again noted to be lying uncovered on top of the plastic 3 drawer storage tote in his shared bathroom.

R33's April 2023 electronic medical record nursing assistant documentation indicated a task

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of "Indwelling Catheter" and "Q [Every] Shift" for documentation of staff initials. On 4/2/23, 4/3/23,4/4/23 and 4/5/23 there was documentation of two staff initials indicating that catheter cares had been provided on two out of the facilities three shifts.

When interviewed on 4/4/23 at 7:28 a.m., nursing assistant (NA)-C stated staff change R33's catheter bed bag to a leg bag in the mornings with cares. NA-C stated she would normally drain the bed bag into the toilet in the resident's bathroom and use an alcohol wipe to clean the tubing then store the bag in the resident's bathroom in or on top of his storage tote and then attach the leg bag which had been cleaned by p.m. staff the evening before.

When interviewed on 4/5/23, at 3:59 p.m. NA-B stated she would assist R33 in the evening by performing peritoneal cares and changing the catheter leg bag to his bed bag by first draining then cleaning the drain tube with an alcohol wipe. NA-B stated staff usually kept a plastic basin on top of the storage drawers in his bathroom to put the bags in however there wasn't currently one available so she would place it on top of the drawers. NA-B stated she didn't know if there was anything else she needed to do after changing R33's leg bag to a bed bag and day shift staff must flush the bags with water.

When interviewed on 4/6/23, at 8:29 a.m. NA-A stated after staff wash and rinse R33's catheter tubing, staff would put the bags in a gray basin and take them to the utility room down the hall and run tap water though them from the sink faucet then drain them into the utility room hopper. NA-A stated staff would then bring the

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basin with the bags in it back to R33's room and store them in one of the drawers of his 3-drawer tote. NA-A acknowledged there was currently no basin in R33's bathroom or utility room for this purpose.

When interviewed on 4/6/23, at 10:07 a.m. the director of nursing (DON) stated R33 had returned from his last hospitalization on 3/15/23 with an indwelling Foley catheter and an order for Foley catheter cares, however, no orders for catheter size and frequency of changes had been obtained from R33's provider. The DON stated a catheter order normally indicates a diagnosis for use, the size of the catheter and frequency of changes at 30 days. The DON stated the responsibility for obtaining the orders would be on the facility. The DON stated R33 had been seen by his provider on 3/17/23 but there was no acknowledgement of an indwelling Foley catheter or any orders for care in the visit summary. The Don stated R33 was again seen by his provider on 3/21/23 and the indwelling Foley catheter was acknowledged as being present but no orders were given regarding care in the visit summary. The DON stated the nursing assistants provide the daily care of R33's catheter including measuring of output and changing of the bed bags and leg bags with cares. The DON stated the nursing assistants would document this care under Point of Care in the electronic medical record. When asked how catheter cares were to be performed the DON stated the catheter leg bag or bed bag would be drained then taken to the utility room in a basin covered with a towel and then rinsed with vinegar. The DON stated she was unaware of how the nursing assistants were currently cleaning and storing R33's urinary drainage bags or how long it had been since his

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bags had been replaced with new ones. The DON stated she should be aware of how R33's catheter cares were being performed. When asked if lack of proper catheter cares could increase R33's his risk for infection given his recent history of sepsis, the DON stated, "No comment." The DON stated she was currently getting a new process in place for cleaning the catheter bags in place and that staff would be re-educated on catheter cares.

R22

R22's admission MDS dated 2/20/23, identified cognitively intact with diagnoses including heart disease and dementia. R22 required extensive assistance with most activities of daily living (ADL's). R22 had an indwelling catheter.

R22's care plan dated 2/13/23, identified R22 had an alteration in elimination and directed staff to provide assistance with peri-cares AM (morning), HS (night) and PRN (as needed), change Foley catheter per policy and Foley catheter care per policy. Also identified R22 had an alteration in skin integrity and directed staff to monitor skin integrity daily during care with a weekly skin inspection by nurse, monitor for skin breakdown for signs/symptoms of infection and report signs/symptoms to MD or PA-C, and document on skin condition and keep MD or PA-C informed of changes. Also identified R22 had an alteration in comfort and directed staff to provide nonmedicinal forms of pain relief such as positioning, rest, massage, etc. and to encourage resident to verbalize discomfort.

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On 4/2/23, at 6:22 p.m. R22's catheter bag was in place and secured on lower left leg. Left leg was purplish red in color and had swelling present. Bottom band of leg bag was indented approximately 0.5 inches into R22's leg, just above the left ankle. At 6:26 p.m. had registered nurse (RN)-A come to R22's room to assess leg and catheter bag. RN-A came and stated, "That is how it normally is, her legs are always swollen." RN-A stated the leg band was not too tight, "no, that is how it always is as her legs are always swollen" and RN-A did not attempt to loosen catheter leg band. At 6:29 p.m. had director of nursing (DON) come to R22's room to assess leg and catheter bag. DON stated if R22 doesn't lay down she has edema as "gravity works." DON assessed leg band and stated "yeah, they got that on there snug." DON asked R22 if it hurt with R22 stating "yeah." DON loosened and readjusted catheter leg bag band.

On 4/5/23, at 9:42 a.m. R22's catheter bag was in place and secured on lower left leg. Bottom band of leg bag was indented approximately 0.5 inches into R22's leg, just above left ankle, and skin had a reddened line present under band location.

During interview on 4/6/23, at 10:36 a.m. nursing assistant (NA)-D stated training on catheter care is done on facility's education platform, Healthcare academy, and on orientation when first hired. NA-D stated catheter bags are switched from a leg bag to an overnight bag before bed. NA-D stated that when applying R22's leg bag in the morning, she waits until the resident gets up out of bed to make sure that it is not too tight. NA-D stated, "because it cuts the circulation off and makes legs swollen."

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During interview on 4/6/23, at 12:51 p.m. DON stated if any nurse had an observation of leg band being too tight, she would expect the nurse to do the same thing that she did such as assessing it and "loosening the leg band so that it was not too tight and painful." DON stated that catheter bags are changed out weekly or as needed and that most residents have a leg bag and an overnight bag but that some residents prefer not to have a leg bag. DON stated staff are trained on catheter cares at hire.

The facility's Catheter Care, Urinary policy dated 9/14 indicated to secure catheter utilizing a leg band with no additional information noted about placement, how to secure leg band, or monitoring skin where the rubber leg band is secured.

R25

R25's admission MDS dated 3/14/23, identified R25 had severe cognitive impairment and was not able to clearly communicate his needs and wishes. Further, R25 required extensive assistance for ADL's. R25's diagnoses included, a stroke with dysphagia (difficulty swallowing) and aphasia (difficulty speaking). R25 had an indwelling catheter for urine drainage.

R25's care plan dated 3/7/23, identified R22 had an alteration in elimination and directed staff to provide assistance with peri-cares in the morning, bedtime and as needed, provide incontinent products and assist to change as needed, monitor Foley catheter output, change Foley catheter per policy and Foley catheter care per policy.

On 4/4/23, at 7:21 a.m. R25 was sitting in

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F 690	Continued From page 24 wheelchair drinking a cup of soda. R25 had catheter leg bag placed on left leg. No overnight catheter bag was present in R25's room or bathroom. On 4/5/23, at 9:35 a.m. R25 was lying in bed and had catheter leg bag placed on left leg. No overnight catheter bag was present in R25's room or bathroom. On 4/6/23, at 1:14 p.m. R25 was lying in bed and had catheter leg bag place on left leg. No overnight catheter bag was present in R25's room or bathroom. When R25 was asked if his catheter leg bag gets changed over to a different catheter bag, not secured on his leg, at bedtime R25 stated "no." When asked if his catheter leg bag always is on, even during the night, R25 stated "yes." On 4/6/23, at 1:50 p.m. R25 was lying in bed and leg catheter bag was more than ¾ full of urine with urine backing up tubing to insertion site. At 1:54 p.m. had DON come to R25's room to assess catheter bag. When arriving to R25's room, trained medication aide (TMA)-A was in the process of emptying catheter bag. When DON was asked where R25's overnight catheter bag is stored, DON went into R25's bathroom and looked but was not able to find one. TMA-A stated that it might be in the north utility room. Writer and DON went to north utility room with no overnight catheter bag found. DON asked NA-E, who was standing in the hallway, "if I was R25's overnight bag where would I be?" NA-E stated "nonexistent." DON asked why R25 did not have an overnight bag with NA-E stating "because there is none in the facility." DON asked NA-E if R25 had an overnight bag the night before last	F 690		

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with NA-E stating "no, it has been over a week since he had one, I wrote a note about it." DON stated, "he doesn't have one right now." DON stated that if a resident only has a leg bag, it needs to be emptied more than once a shift and should be emptied before it gets ¾ full. DON stated, "the reason you don't want it to back up is, so they don't get a UTI (urinary tract infection)."

During interview on 4/6/23, at 10:36 a.m. NA-D stated training on catheter care is done on facility's education platform, Healthcare Academy, and on orientation when first hired. NA-D stated catheter bags are switched from a leg bag to an overnight bag before bed."

During interview on 4/6/23, at 12:51 p.m. DON stated catheter bags are changed out weekly or as needed and that most residents have a leg bag and an overnight bag but that some residents prefer not to have a leg bag. DON stated staff are trained on catheter cares at hire.

The facility policy Disinfection of Urinary Drainage Bag dated December of 2015, identified the purpose and frequency was "To clean and disinfect urinary drainage bag. To prohibit the growth of bacteria. Daily, when urinary drainage bag is removed from resident." The policy indicates the supplies needed as "1. Disposable gloves (2 pair) 2. Alcohol swab 3. Container for storage 4. Clean bath towel 5. 55-65 cc vinegar 6. Plastic disposable cup 7. Measuring container" The policy indicated the steps of the procedure as "1. Wash hands. 2. Supplies will be stored in resident room, vinegar, gallon container with plastic disposable cups, alcohol swabs, gloves and paper towels are available in private resident bathrooms. If the resident shares a bathroom,

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F 690	Continued From page 26 these supplies will be stored in the resident room. 3. Introduce self and inform resident of what you will be doing. 4. Put on first pair of disposable gloves. 5. Uncap bottom outlet of bag, drain urine into measuring container, then recap outlet. 6. Measure urine and dispose of in toilet. 7. Remove gloves. 8. Wash hands. 9. Put on second pair of disposable gloves. 10. Before disconnecting, cleanse both connecting ends of catheter and tubing with alcohol swab. (This prevents bacteria from entering the catheter end when the bag is disconnected.) 11. Disconnect the bag from the catheter, being careful not to contaminate the connecting ends by touching other surfaces. 12. Connect the drainage bag to the catheter. 13. Remove gloves and dispose of them in waste container. 14. Make resident comfortable with signal light within reach. 15. Record amount of urine in bag. 16. Remove top cap. Partially fill the bag with 55-65 cc of vinegar. 17. Shake the bag gently so the entire inside of bag is rinsed well. 18. Drain vinegar from bag, store bag on clean towel or in clear plastic bag until next use; allowing exterior to air dry. 19. Wash your hands. 20. Change out bag for new appliance on bath day."	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		5/24/23

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of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to complete accurate assessments, interventions and ongoing weight monitoring, meal refusal monitoring and availability of fluids to address unplanned weight loss for 1 of 1 resident (R25) reviewed for nutrition and hydration.

Findings include:

R25's admission Minimum Data Set (MDS) dated 3/14/23, identified severe cognitive impairment, an inability to communicate needs, required extensive assist for most activities of daily living (ADL's). R25 required supervision, oversight, encouragement or cueing along with set up help for eating. R25 weighed 207 pounds and did not have any known weight loss or gain in the prior 6 months. R25 had received speech-language pathology services during the assessment period. R25 did not reject cares. It was somewhat important to R25 to have snacks available between meals. R25's diagnoses included, a stroke with aphasia (difficulty speaking), and dysphagia (difficulty swallowing), low blood

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R25 was assessed by the Nurse Practitioner and Dietitian for weight loss. IDT reviewed and updated R25s dietary interventions.

R25 and like residents weights and meal refusals will be reviewed on a weekly basis.

Water pass was initiated for all residents two times a day.

All residents have the potential to be affected.

All GAW staff have been re-educated to the requirement/regulation.

Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence.

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F 692	Continued From page 28 sodium, diabetes and kidney failure. R25's care plan dated 3/7/23, identified R25 required additional monitoring due to current nutritional status and was at risk due to mechanically altered diet. R25's goal was to maintain adequate nutritional status and to consume 75 percent or more of meals. The care plan directed staff to provide a diet per medical doctor order, obtain weight monthly, record nutritional intakes per facility protocol, must be up in chair at 90 degrees for all meals, dietary preferences - refer to tray ticket, obtain/review labs per MD order and diuretic per MD order. The care plan did not identify any approaches to use if R25 was refusing meals and did not identify any current weight loss. R25's Therapy to Nursing Communication - Resident Status update, dated 3/10/23, specified R25 was now on a mechanical soft diet, must be up in chair 90 degrees for all meals and to ensure ground meats are moistened to proper texture - meats - may not be served dry. Form was completed by speech therapist (ST). Dietary reviewed, signed, and dated form on 3/13/23. R25's weights documented on the admission orders and Medication Administration Record, identified the following: -3/7/23: 204.2 # (pounds) (hospital discharge weight per discharge orders) -3/7/23: 206.5 # (weight on facility scale) -3/26/23: 186.5 # (9.69 % weight loss) -4/2/23: 183 # (1.88% weight loss) Total of 11.38% weight loss in 27 days, which was flagged in red on the electronic medical record for staff to note.	F 692	Director of Nursing or designee is responsible party.	

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R25's percentage of amount eaten from 3/7/23 to 4/3/23, identified R25 refused 16 meals out of 50 meals total.

The MHM Clinical Nutrition Evaluation, dated 3/16/23, and was completed by registered dietician (RD) indicated:
Most recent weight: 206.5 on 3/7/23
Usual body weight: 200
Weight History: 30 Day weight: 200
Weight History: 180 Day weight: 200
Loss of 5% or more in the last month or gain of 10% or more in last 6 months: No or unknown
Gain of 5% or more in the last month or gain of 10% or more in last 6 months: No or unknown
Diet order: ConCHO/2GmNa/Mech Soft (consistent carbohydrate/2 gram sodium, mechanical soft)
Food/Calorie Intake by: Oral
Meal intake: 51-75%
Fluid Intake: Consumes 1000-1499cc (cubic centimeters)/day
Supplements: None
Amount of feeding assistance required: Independent
Under the summary the assessment identified, hospital weight of 204, with a weight history of 200-210#. R25 had dentures he did not wear, but had not problem eating meals. Was on a mechanical soft diet, had no swallowing or chewing problems. It was recommended to add a supplement of Pro Stat 30 cc every day. Meal intake was variable. Staff were to offer snack, monitor and document meal intakes and obtain weight per policy. The Registered dietician to follow up as needed with changes in meal intakes, weights or skin concerns.

R25's dietary slips from 4/2/23 and 4/5/23,

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identified a 2 gram sodium consistent carbohydrate mechanical soft diet with ground meat.

The Group Assignment Sheet (nursing assistant care sheet) directed R25's weekly weight was scheduled on Mondays, was to be up in wheelchair for all meals, and diet was Consistent Carbohydrate diet, Regular texture, Regular (thin) consistency (liquids).

On 4/2/23, at 3:14 p.m. R25 was coughing. At 3:15 p.m. staff went into room and asked R25 if she could assist him with sitting up in bed with R2 stated, "No."

On 4/2/23, at 6:03 p.m. R25 was in a lying position in his bed with the head of bed elevated 25-30 degrees and was sliding down in bed so that his feet were touching the foot board. R25 was attempting to drink water out of his water pitcher, R25 was coughing. Upon further observation, the water pitcher was empty. At 6:04 p.m. registered nurse (RN)-A went into R25's room and asked him why he didn't eat supper. RN-A asked R25 if he would like an Ensure (supplement), R25 stated, "No." RN-A left room without exploring other intake options or filling the water pitcher.

On 4/3/23, at 1:50 p.m. R25 was laying in bed watching television. R25 stated he had not eaten his lunch.

On 4/4/23, at 7:21 a.m. R25 was sitting up in wheelchair drinking a cup of soda. R25's water pitcher was empty. At 8:41 a.m. R25 was observed eating in the dining room with R25 had eaten 100% of breakfast and drank 100% of his

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water and juice.

On 4/4/23, at 7:53 a.m. observed refrigerator in dining room, where sandwiches were kept, with their only being deli sandwich option of turkey and cheese available. No ground meat or salad sandwiches were available.

On 4/4/23, at 12:43 a.m. R25 was sitting in wheelchair in his room with no water in water pitcher. At 3:13 p.m. no water was in the water pitcher.

On 4/5/23, at 8:50 a.m. R25's water pitcher was half full. At 8:51 a.m. R25 was observed eating in the dining room R25 ate 100% of breakfast and drank 100% of his water and juice.

On 4/6/23, at 1:14 p.m. R25 was laying in bed, was pale in color and skin and tongue were dry. R25's water pitcher was empty.

During interview on 4/2/23, at 3:50 p.m. family member (FM)-A stated the facility does not notify her of concerns/changes right away and that they wait to notify her until she comes to visit. FM-A stated that when she comes to visit there is, "never any water" in R25's room. FM-A stated she went up to the nurse's station 3 different times requesting water for R25 before staff brought some water into room for R25 an hour later.

During interview on 4/3/23, at 3:48 p.m. trained medication aide (TMA)-D stated, R25 feeds self with no assistance needed. TMA-D stated R25 refuses cares frequently and sometimes he won't eat. If R25 is refusing meals, a nurse will go in to reapproach R25 and if R25 continues to refuse there are sandwiches in the refrigerator that they

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bring him to eat later.

During interview on 4/3/23, at 4:11 p.m. TMA-C read information off nursing care sheet, she stated she was not that familiar with R25. TMA-C stated that R25 is an assist of 2 with sit-to-stand, needs to be up in w/c for all meals and eats a regular diet.

During interview on 4/3/23, at 4:14 p.m. TMA-B read information off nursing care sheet, as she stated she was not that familiar with R25. TMA-B stated that R25 is an assist of 2 with sit to stand, has catheter and eats a regular diet.

During interview on 4/3/23, at 4:18 p.m. registered nurse (RN)-A stated R25 eats meals in the dining room due to choking risk as he has choked on medications. RN-A stated R25 has memory concerns, refuses repositioning at times, and occasionally will refuse a meal in the evening. RN-A stated when R25 refuses a meal, she brings a sandwich to R25's room later.

During interview on 4/5/23, at 11:50 p.m. registered nurse (RN)-B stated, the NA's document weights and would let a nurse know if a resident had lost weight. The nurse would assess and request the resident be reweighed. If the weight continued to be a significant loss, the nurse would do an assessment, document it and update the provider. Also the NA's let the nurse know if a resident is refusing a meal, the nurse will then reapproach the resident. If there are multiple refusals, the provider would be contacted. The night shift fills the water pitchers in resident rooms and they can be filled by other shifts if staff note they are empty. RN-B was not aware R25 had a significant weight loss.

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During interview on 4/5/23, at 3:29 p.m. the ST stated communication of changes or new orders are being worked on lately. ST stated they use a therapy to nursing communication form where they fill out with specific recommendations, sign, and date form. ST makes copies and hands them out to the appropriate staff members. One is placed in the therapy alert binder, one copy Is given to the licensed practical nurse (LPN) Care Coordinator, one copy is given to the culinary direct and one copy is posted at the nurse's station. In addition to handing form out, ST stated that she will also verbally update the staff that needs the information immediately such as, nurses and nursing assistants. ST stated a sandwich is not an option for a resident on a mechanically soft diet due to the National Dysphasia Diet group. ST stated that an in-service was done with dining where it was reviewed that if everything is moist, plenty of mayo is on bread, and there is no crust on the bread that a sandwich may be utilized. ST stated R25 should not be offered a deli meat sandwich due to being on a mechanically soft diet. ST stated R25 needs to be fully upright at a 90-degree angle, for all oral intake (food, liquids, and medications) due to swallowing difficulties and risk for choking/aspiration. ST stated R25 needed to be checked on frequently to ensure safety and due to his memory concerns, needed reminders to sit up if he was laying down and was reaching for his drink.

During interview on 4/5/23, at 4:00 p.m. director of nursing (DON) stated the care sheets are updated by the LPN Care Coordinator and the information is directly from the care plan, which is done by the assessments or therapy

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F 692	Continued From page 34 recommendations. DON stated that the NA's, nurses, and DON will refer to the care sheets. DON stated staff are trained on mechanically soft diet during the CNA class and is part of the orientation training plan. DON stated the registered dietician (RD) monitors resident weights the most and depending on which resident, the DON will also review weights if it is triggered on the dashboard. DON stated if she noticed an abnormal weight, when the nurse practitioner comes to the facility on rounds, she would notify provider on site of weights. DON stated once the RD reviews weights, she would send out an email with a recommendation and then a referral would be sent to provider via the physician portal. DON stated if the provider would have been notified about the weight loss that there would have been documentation in the progress notes. DON stated that the provider also has access to PCC (point click care- the electronic medical record) to review resident's chart. DON stated if a resident refuses care, medication, meals, treatments more than 3 or 4 times, DON would start looking into it more and would notify family and provider. DON stated if a dementia resident is refusing, staff need to reapproach and if that does not work then another staff member needs to approach resident to attempt assistance. DON stated if it is common for a resident to refuse certain tasks, then it should be care planned that resident refused services. DON stated care plans are updated by the nurses, MDS nurse, nurse managers and the DON. DON stated when a resident is refusing meals, she would speak to family to review residents likes and dislikes, keep attempting to encourage resident to eat and monitor weights. After reviewing R25's medical record, DON stated R25 is typically refusing one meal a day and	F 692		

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F 692	Continued From page 35 when R25 does eat he is eating 75-100% of most meals. DON stated R25's diet was consistent carb/2 gm sodium/mechanical soft diet which started on 3/14/23. DON stated R25 was on a regular texture diet when admitted and ST assessed him as R25 was coughing when he was eating. DON stated R25 was at risk for aspiration and should be sitting up for all oral intakes. DON stated R25 weekly weights are scheduled on Sundays since 3/12/23 as R25 was admitted on 3/7/23. DON stated it is the NA and nurses' responsibility to obtain weights. DON acknowledged that R25's weight was not obtained for 2 weeks. DON stated there is an order for weekly weights so the nurses should be entering weights. DON stated, "there is absolutely nothing marked on either documentation places (computer or weekly weight sheet)." When DON reviewed R25's weights she stated, "Yes that is a significant weight loss." DON stated that the provider had not been notified of weight loss and that she would be sending a message via the portal immediately. DON confirmed that R25's discharge weight from the hospital on 3/7/23 was 204. DON reviewed R25's weights and diet on care sheet and read "weights on Monday and diet is regular texture. They put it in wrong as diet on here is incorrect." Culinary Services Director was reviewing diets today (4/5/23) and making changes. DON stated if a resident was requesting food due to being hungry staff would refer to the care sheets for resident's diet. When asked if R25 could have a sandwich, DON stated "yes a sandwich is an option for a mechanical soft diet, tuna or ham salad, but no deli sandwiches." At 4:33 p.m. DON notified writer that the reason why those two weeks of weights were not taken is due to R25 being on contact precautions for C-Diff (clostridioides difficile) infection. At 4:37 p.m.	F 692		

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F 692	Continued From page 36 writer visualized facility's wheelchair scale, scale has wheels and can move without difficulty. During interview on 4/6/23, at 8:38 a.m. nurse practitioner (NP) stated that the facility had not notified her of R25's weight loss and that she was also not notified while she was on site during rounds. NP stated that if she would have been notified of weight loss that she would have reviewed and would have placed a referral to a registered dietician, add a house nutritional supplement to make sure that resident was receiving enough calories and order more frequent weights for monitoring. The NP stated R25's nutritional status could have impacted his skin integrity with a newly developed pressure ulcer, but other factors would have also played a role. During interview on 4/6/23, at 9:05 a.m. RD stated that when she was reviewing weights on 4/2/23, she had reached out to the facility for a reweight on R25. RD stated that reweight was done but was not able to give the weight that was obtained. RD stated that she is following up on R25's weight currently and is reassessing R25 and will probably add on a supplement to make sure that he is following the diet. RD stated that the registered dieticians review and monitor resident's weight but that there has been a switch due to the other RD being on maternity leave. RD stated that weights are also reviewed at morning meetings. RD stated she was not notified or aware of R25's refusals of meals. RD stated she is reviewing, will document and update the care plan. The Guidelines for completing Dietary Intake, dated 9/12 indicated 1. Nursing or hospitality	F 692		

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F 692	Continued From page 37 services staff are responsible to document intake. 2. The Dietary Intake is completed following each meal (breakfast, dinner, and supper) using 0, 25, 50, 75, or 100% to document amount consumed of each food item. An "x" should be entered if the item was not served at that meal. 3. For quarterly assessments, the Hospitality Services Manager will summarize the Dietary Intake, to be transferred to the "Amount of Food Eaten" section of the Nutrition Assessment Form. This form is kept in the resident's medical record. 4. After all information has been completed for the month, the Dietary Intake is filed in a location designated by the Culinary Services Director to be available for the Registered Dietitian. They will be kept as reference for a 3-month period. The Care Plans, Comprehensive Person-Centered, dated 12/16 indicated assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions changes. A policy on resident's weight and hydration was requested but not received.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		5/24/23

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F 755	Continued From page 38 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure supply and administration of ordered medications for 2 of 2 residents (R35 and R20) reviewed for pharmacy services. Findings include: R35's quarterly Minimum Data set (MDS) dated 1/26/23 indicated he was cognitively intact and had a diagnosis of anxiety. R35's Care Area Assessment worksheet dated 10/27/22, indicated "Psychotropic drug use" and "staff will continue to follow plan of care to aide in prevention and manage any potential negative	F 755	R35s medications were supplied and administered. R20s medications were discontinued per NP orders. All residents have the potential to be affected if this requirement is not met. All GAW staff have been re-educated to the requirement/regulation. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at	

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F 755	Continued From page 39 outcomes related to meds including admin [administration] meds [medications] as ordered," R35's Diagnosis Report dated 4/6/23, indicated he had panic disorder and general anxiety disorder. R35's care plan focus dated 9/11/22, indicated he had an alteration in mood and behavior due to diagnoses of major depressive disorder and anxiety disorder and directed staff to provide medications per order. R35's provider visit notes dated 2/14/23, indicated "he continues to report significant issues with anxiety, is resistant to any medication reductions, and is managed on Venlafaxine [an antidepressant] Clonazepam [anxiolytic] and Diazepam [anxiolytic/sedative.]" R35's Order Summary Report dated 4/6/23, indicated a medication order for Clonazepam one milligram (mg) three times a day related to panic disorder with a start date of 2/27/23. When interviewed on 4/2/23, at 1:31 p.m. R35 expressed concern regarding the facility running out of his Clonazepam medication in February. R35 stated it was very frustrating to him as because the facility was responsible for ordering his medications and he should not have run out. R35 stated his Clonazepam used to be scheduled and he normally took it three times a day. R35 stated at some point his Clonazepam order got changed to as needed three times a day and he had to ask for it. R35 stated he had wanted and requested a third dose of Clonazepam on the evening of February 22nd and the morning of February 23rd and was told there was no supply.	F 755	the time of occurrence. Director of Nursing or designee is responsible party.	

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R35 stated he remembers these dates specifically as he was very upset with the staff that he had run out. R35 again stated he would normally take the Clonazepam three times a day as it had been scheduled that way in the past.

R35's February 2023 Medication Administration Record (MAR), indicated an order for Clonazepam one mg as needed for anxiety three times a day with a start date of 1/20/23 and discontinue date of 2/27/23. R35 received 2 doses of Clonazepam on February 22nd at 9:11 AM and 1:33 p.m. R35 received 2 doses of Clonazepam on February 23rd at 3:16 p.m. and 8:32 p.m. The documentation space for a third dose was left blank on both days.

R20's MDS dated 38/23, indicated he was cognitively intact and had a diagnosis of chronic obstructive pulmonary disease (COPD).

During a medication pass observation and interview on 4/3/23, at 9:22 a.m. trained medication aide (TMA)-A stated R20 had an order for Arnuity Ellipta which is an inhaler for his COPD at this time, but she could not give it as it had not arrived from the pharmacy yet. When asked what she would document on R20's MAR, TMA-A stated she was instructed by licensed staff not to document anything and let a charge nurse know so they could follow-up on why the medication wasn't in. When asked about the re-order process, TMA-A stated when a resident's supply gets low, she was able to re-order through the MAR itself and the request would go directly to the pharmacy.

R20's March and April 2023 MARs indicated he had an order for Arnuity Ellipta 200 MCG/ACT

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(micrograms/actuation) Aerosol Powder (inhaler), breath activated one puff orally in the morning for COPD with a start date of 12/31/22.

R20's March and April 2023 MAR lacked any documentation for his ordered doses on 3/5/23, 3/7/23, 3/8/23, 3/9/23, 3/13/23. 3/14/23, 4/2/23 and 4/3/23.

R20's progress note dated 4/1/23 at 9:59 a.m., indicated his Arnuity Ellipta medication was unavailable.

R20's progress note dated 4/3/23 at 9:47 a.m., indicated "Per pharmacy consult, reviewed resident for polypharmacy. Per NP, ok to d/c (discontinue) Ellipta, MV (multivitamin), cranberry tabs.

When interviewed on 4/4/23 at 8:52 a.m., TMA-B stated if a resident's medication was out, she would let the charge nurse know. TMA-B stated she was instructed not to document anything on the MAR by the licensed nurses so they would have the opportunity to figure out where the medication was.

When interviewed on 4/6/23 at 8:53 a.m., registered nurse (RN)-B stated when R35 was admitted his Clonazepam was scheduled three times a day and then one of his providers changed it to as needed three times a day, so he needed to ask for it. RN-B stated the Clonazepam order was changed back to scheduled three times a day on 2/27/23. RN-B stated the facility had transitioned from using Thrifty White Pharmacy to Polaris Pharmacy in the beginning of December and staff had to learn a new ordering process. RN-B stated if the medication

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was not available, staff would leave the MAR blank and let the nurses know so we could follow-up with pharmacy. When asked about the missing documentation on the MARs for R35 and R20, RN-B stated she would consider that to be an omission medication error, however no medication error incident had been initiated.

When interviewed on 4/6/23 at 10:07 a.m., the director of nursing (DON) stated the facility is responsible for ordering medications including obtaining signed prescriptions if needed. The DON stated R35 did miss 2 requested doses of Clonazepam because there was a delay in getting the needed signed prescription and would consider this a medication error. The DON stated she would consider the lack of R20's Ellipta inhaler to be a medication error as well. The DON stated medications should be ordered when the supply gets down to 7 days to ensure not running out. The DON stated staff were instructed to not document "no supply" on the MARs to remind them to let the charge nurse know the medication wasn't available. The DON stated sometimes the charge nurse will get an order from the provider for a late administration of the medication in case it would arrive outside the administration time, and this would be another reason staff would not immediately document anything on the MAR. When asked about the medication error process, the DON stated staff should initiate a facility medication error form but that had not been done with R35 or R20. The DON stated she would be re-educating staff on what constitutes a medication error and what to do if one occurs as well as the medication ordering process.

The facility policy Documentation of Medication Administration dated April 2007, indicated

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F 755	Continued From page 43 "Documentation must include, as a minimum: Reason(s) why a medication was withheld, not administered, or refused (as applicable)". The facility policy Medication and Treatment Orders dated July 2016, indicated "Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available." The facility policy Medication Error Procedure dated January 2020, indicated when a medication error occurs, the person responsible for the error or finding the error should complete a Medication Error Reconciliation report and document information on the error, notify the provider, notify the resident, notify the resident representative, and notify the DON or designee. The Medication Error Procedure indicated there would be a meeting with the person(s) making the error and record follow-up action and education. The Medication Error Procedure indicated medication errors would be routed to the administrator and data would be complied regarding medication errors and adverse consequences would be brought to the facility Quality Assurance meeting monthly. The facility Medication Error Reconciliation Form dated September 2011, indicated "Omission (missed dose/s)" as one type of nursing medication error.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		5/24/23

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F 756	Continued From page 44 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 756	R33 pharmacist consult	

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F 756	Continued From page 45 facility failed to ensure pharmacist consultant recommendations were acted upon for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: R33's significant change in status Minimum Data Set (MDS) dated 2/17/23 indicated he had moderately impaired cognition, was frequently incontinent of bowel, had a diagnoses including, Parkinson's Disease and psychotic disorder and received antipsychotics and antidepressant medications. R33's Consultant Pharmacist's Medication Review dated 11/5/22, indicated a recommendation to place standing orders for orthostatic blood pressures every month related to anti-psychotic use. The medication review indicated antipsychotics could cause orthostatic hypotension. R33's physician orders dated 4/2/23, indicated he was receiving the anti-psychotic medication Quetiapine Fumarate 12.5 mg (milligrams) two times a day for Psychosis related to Parkinson's Disease. R33's orders also indicated to monitor orthostatic blood pressures lying, sitting, and standing on the 3rd of every month. R33's care plan focus dated 3/30/23, indicated a potential for psychotropic drug adverse drug reactions (ADR's) related to daily use of psychotropic medication but provided no instruction to monitor orthostatic blood pressures monthly per pharmacy consultant recommendation on 11/5/22. R33's care plan focus dated 3/30/23, indicated he had an	F 756	recommendations were followed up on. All residents have the potential to be affected if this requirement is not met. All GAW staff have been re-educated to the requirement/regulation. Director of Nursing or designee will complete pharmacy recommendations each month when they are received. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party.	

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F 756	Continued From page 46	F 756		

alteration in mobility related to weakness and Parkinson's Disease and instructed staff to provide assist of one with a front wheeled walker for transfers. R33's care plan focus dated 9/16/22 indicated he was a fall risk related to impaired mobility, weakness, history of falls and diagnosis of Parkinson's Disease.

R33's March 2023 Treatment Administration Record indicated instruction for "Psychotropic Monitoring - Antipsychotic Medication: Monitor for potential side effects: drowsiness, dizziness, orthostatic hypotension, weight gain, anticholinergic symptoms, extrapyramidal reaction" and was initialed by staff on March 5, 2023; however, there was no documentation of orthostatic blood pressure values indicated.

R33's vital signs record indicated regular blood pressures were completed several times in March 2023 but no orthostatic blood pressures including lying, sitting, and standing were done.

R33's Consultant Pharmacist Medication Regimen Review dated 2/27/23, indicated a recommendation regarding his medication orders for the anti-diarrheal medication Loperamide and the supplement Magnesium stating "Please note that magnesium products can cause diarrhea. Please assess the risk vs the benefit of the current regimen."

R33's provider visit notes dated 3/3/23, indicated he was seen onsite by his provider with no documentation of review of the pharmacy recommendation for his Loperamide and Magnesium medications.

R33's orders dated 4/2/23, indicated he was still

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F 756	Continued From page 47 receiving the supplement Magnesium Oxide 250 milligrams (MG) daily for Hypo magnesia and the anti-diarrheal medication Loperamide HCL 2 mg (milligrams) every day with no indication for use. When interviewed on 4/6/23 at 8:53 a.m., registered nurse (RN)-B stated the facility pharmacy consultant comes to the facility monthly to review all the resident's medication orders. When done, the pharmacy consultant will provide a form indicating any recommendations for the staff or the resident's provider to follow-up on. If the recommendation is something the provider needs to follow-up on, then a licensed nurse will fax the form to them for review. RN-B stated after faxing the form, "we then put it in a desk organizer at the nurse's station and put the fax confirmation sheet in a binder". If the recommendation is for the facility rounding physician who comes onsite weekly, "then we put the form in her folder at the nurse's desk so she can review when she is here". RN-B stated if the provider does not respond, then nursing staff would re-fax the recommendation or bring it to the rounding physician's attention again. RN-B could not recall if R33's pharmacy recommendation regarding for orthostatic blood pressures or magnesium and loperamide had been reviewed by his provider. RN-B stated if the recommendation is for an orthostatic blood pressure check, then a nursing order would be entered into the resident Treatment Administration Record and would include a lying, sitting, and standing blood pressure. RN-B stated vitals including orthostatic blood pressures could be done by nursing assistants, but it would be a licensed nurse's responsibility to check and document the values in the resident's medical record.	F 756		

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When interviewed on 4/6/23 at 10:07 a.m., the director of nursing (DON) stated the pharmacy consultant comes in monthly and provides her with a list of everyone who had medication reviews and provides separate reports for any recommendations. The DON stated she looks though any recommendations and then either places the form at the desk in the onsite rounding physician's folder or faxes it to any outside providers. The DON stated she does this within 2 days of receiving the form from the pharmacy consult. The DON stated she would follow-up to see if a response was received from the provider within a week of sending the form. The DON stated the pharmacy consultant recommendation for R33 dated 11/5/22 regarding orthostatic blood pressures was entered into the treatment administration record, however staff were not completing them correctly. The DON stated the pharmacy consultant recommendation dated 2/27/23 regarding his Magnesium and Loperamide was missed, and not given to his provider resulting in the provider not having the opportunity to review or respond. The DON stated it was the facility responsibility to ensure the pharmacy recommendations were received by and responded to by the provider.

When interviewed on 4/6/23 at 4:15 p.m., the facility pharmacy consultant (Pharm D) stated his expectation for how soon the facility should bring recommendations to the provider's attention could vary depending on the urgency of the situation. The Pharm D stated his expectation was that the facility would ensure the provider had received and reviewed any recommendations he made at least by the next time the resident was seen by the provider. The Pharm D stated

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F 756	Continued From page 49 there is often a recommendation to check orthostatic blood pressures with the use of psychotropic medications because they may contribute to orthostatic hypotension and increase the risk for falls. The facility policy Psychotropic Medication Use dated 7/8/21, indicated "With initiation of an antipsychotic medication, residents who do not require use of a mechanical Hoyer lift will have an orthostatic blood pressure performed on a monthly basis."	F 756		
F 812 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 store food in	F 812	Food storage areas were examined to ensure all food was stored in accordance	5/24/23

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F 812	Continued From page 50 accordance with professional standards for food service safety, monitoring of refrigerator/freezer temperatures and performing proper hand hygiene during meal services. This had the potential to affect all residents, staff and visitors who ate at the facility. Findings include: On 4/2/23, at 11:50 a.m. an initial kitchen tour was completed with lead cook (cook)-A. The following areas of concern were identified. -In walk in cooler the following food items were expired and/or not labeled with dates: container of sliced Swiss cheese, with corner of container open to air, was dated 12/1 and there was approximately 6 slices of cheese that had a white powdery substance on the cheese, cook-A stated, "yes it's moldy"; container of coleslaw with no open date labeled on container; French onion dip labeled 2/6/23; bag of tomatoes with no date; bag of cooked bacon with no date; container of strawberries dated 2/14; open bag of sliced Swiss cheese labeled 11/19; bag of shredded cheddar cheese dated 3/9; bag of shredded mozzarella cheese dated 1/23; bag of shredded Swiss cheese dated 11/10/22, cook-A stated "cheese is dry with white powder substance on it," bag of shredded cheddar cheese with no date, cook-A stated, "turning white"; bag of shredded mozzarella cheese with no date; tin can of corn was covered with tin foil with no date, cook-A stated, "not suppose to store food in cans." -On shelf in kitchen the following food items were expired and/or not labeled with dates: jar of apple butter dated 11/20/22; bag of instant mashed potatoes that was unsealed with no date; opened	F 812	with professional standards for food service safety. Refrigerator/Freezer temperatures were obtained for all fridges/freezers in the facility. Al staff were educated on proper hand hygiene during meal services and to obtain fridge/freezer temperatures. All residents, staff and visitors who eat at the facility have the potential to be affected if this requirement is not met. Regular audits will be completed of food storage areas, fridge/freezer temps, hand hygiene during meal service to ensure compliance. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Culinary Director or designee is responsible party.	

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F 812		F 812		

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container of soy sauce dated 8/4/22 and was not refrigerated per instructions on container; squeeze bottle of a thick yellow liquid with no label of what item was and no date; opened container of sweet teriyaki sauce with no date and was not refrigerated per instructions on container; opened bag of Fritos chips dated 1/23. Cook-A stated, the culinary services director usually ensures food is not expired and is labeled, but all dietary staff were responsible for checking dates.

During interview on 4/2/23, at 2:32 p.m. culinary services director (CSD) confirmed the outdated/expired items. CSD stated it is every dietary staff responsibility to check for expired foods and label all foods with date and they go by a 3-day date window. When CSD stated it was important, "to prevent foodborne illness." When policy was requested CSD stated that she does not have a policy and will get one from corporate. CSD stated she had a monthly staff meeting with culinary staff on 2/28/23 where they reviewed FIFO (first in first out).

On 4/5/23, at 3:52 p.m. unit 6 refrigerator (in resident's visiting area), was observed with many food items not being labeled, dated, and/or were expired. Administrator went through refrigerator and threw away the following items that were not labeled: strawberry cream cheese, 5 containers of yogurt, container of cottage cheese, package of wieners, package of hot dog buns, a McDonald's bag of food and a package of tortilla shells. Administrator also threw away a container of cottage cheese with an expiration date of 2/27/23. Administrator stated it is culinary services responsibility to ensure food items are labeled and disposed of in the correct timeframe.

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Review of kitchen cleaning logs from 3/23 indicated "Check food dates and toss old food" to be completed on morning shift, 13 of the 31 morning shifts were initialed as being completed with the other shifts being blank. "Check cooler for spills & mold," was to be completed on morning and afternoon shift, 11 of the 31 morning shifts and 15 of the 31 afternoon shifts were initialed as being completed with the other shifts being blank.

Staff meeting training PowerPoint slides dated 2/28/23, indicated the following information: "FIFO (First in First out), when storing food or putting away food we need to ensure new product is getting placed behind the old products. Old products should be used before the new products, reducing products likelihood of expiring and needing to be thrown. Food should only be stored for 3 days including the date of making, excluding tuna salads, pasta salads, etc. containing mayonnaise, vinegar, or lemon, those are good for 7 days including date of make."

The Food Receiving and Storage policy dated 10/17, indicated, "Food Services, or other designated staff, will maintain clean food storage areas at all times. All foods stored in refrigerator or freezer will be covered, labeled and date ("use by" date). Other opened containers must be dated and sealed or covered during storage.

The Handling Food Brought in for Resident's Individual Consumption policy dated 1/17 indicated "It is the policy of Monarch Health Care Management to address food brought in from the outside with the intent to serve it to individual residents. All food must be clean, free from spoilage and safe for human consumption. Food

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brought into the facility for particular residents will be assessed by facility staff on an individual basis. Food that is obviously unclean, spoiled, or unsafe will be disposed of properly. The container must be labeled with: Resident name and date the item was received. Food must be disposed of properly after 3 days. Refrigerator and freezer cleanliness will be maintained by facility staff. Cleaning of the refrigerator will occur weekly."

On 4/04/23, at 7:32 a.m. tour of unit 6 refrigerator (resident's refrigerator in visiting room) was completed with CSD. CSD stated the freezer temperature was 1 degree and the refrigerator temperature was 39 degrees. CSD stated the unit "was running higher temps but adjusted some setting and moved the thermometers to the back."

Review of temperature logs from 3/23 for unit 6 refrigerator indicated that the temperature was only recorded once on 3/31/23 for the month of March, with a freezer temperature of 5 degrees and a refrigerator temperature of 44 degrees.

Review of kitchen cleaning logs from 3/23 indicated "Record Cooler & Freezer temps" to be completed on AM shift, 12 of the 31 AM shifts were initialed as being completed with the other shifts being blank.

The Food Receiving and Storage policy dated 10/17, indicated "Refrigerated foods must be stored below 41 degrees F unless otherwise specified by law. Functioning of the refrigeration and food temperature will be monitored at designated intervals throughout the day by the

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F 812		F 812		

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food and nutrition services manager or designee and documented according to state-specific requirements. All food belonging to residents must be labeled with the resident's name, the item and the "use by" date. Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines."

The Handling Food Brought in for Resident's Individual Consumption policy dated 1/17 indicated "Refrigerator and freezer temperatures will be monitored on a daily basis to ensure they are within acceptable range."

On 4/4/23, at 8:36 a.m. dietary aide (DA)-A was serving breakfast to residents in the dining room. DA-A was wearing gloves that were ripped at the cuff of the right glove and did not change them to a new pain. DA-A touched refrigerator handle, poured cereal in a bowl with her thumb touching the inside of bowel, touched all meal tickets and was serving beverages. While serving beverages, DA-A placed finger inside of coffee cup and milk cup around lip of cup. At 8:47 a.m. DA-A touched the top rim, where resident places lips, of a juice cup and carried it to the resident by the rim. At 8:48 a.m. DA-A touched the handle of a resident's wheelchair with her gloved hands and did not change gloves before serving next resident. At 8:55 DA-A touched a resident's piece of toast to hold it for RD who was applying jelly. DA-A touched resident's shoulder, with gloved hands, when delivering the toast. At 8:58 a.m. DA-A unwrapped straw and placed the end of the straw, that she touched, in beverage. At 9:00 a.m. DA-A touched her shirt to readjust with both

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F 812	Continued From page 55	F 812		

gloved hands. At 9:03 a.m. DA-A touched handle of a resident's wheelchair with gloved hands. At 9:11 a.m. DA-A touched the rims of 2 juice cups that she was preparing for room trays. At 9:17 a.m. DA-A removed the pair of gloves, that were ripped on the right cuff, that she was wearing during the entire meal service without changing gloves or performing hand hygiene. DA-A did not perform hand hygiene after removing gloves and going to next task.

During interview on 4/4/23, at 9:45 a.m. DA-A stated that she should be changing her glove "anytime I touch anything that I shouldn't touch." DA-A stated she changes her gloves between every task, describing that she considered serving drinks and plates are one task and cleaning in considered another task. When DA-A was asked how many times she changed her gloves during this meal service, DA-A stated "once." When DA-A was asked why it is important to change gloves and perform hand hygiene, DA-A stated, "so we don't spread germs."

During interview on 4/06/23, at 3:49 p.m. infection preventionist (IP) stated that her expectation of hand hygiene in dining room is "Wash your hands before going in there, and in between when they are touching the chairs, etc. that aren't food. Servers need to be wearing gloves when serving. If they are touching other things besides serving, then they need to change gloves in between and wash their hands before applying new gloves". IP stated that hand hygiene audits have not been done since she came which was in mid-December of 2022 and that she did not review or look at anything Infection Control until mid-February of 2023. IP stated that there have been no foodborne illnesses. When IP was asked

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F 812	Continued From page 56 why hand hygiene and monitoring/audits of hand hygiene are important, IP stated "because we are in trouble if bacteria is being spread all over by not doing hand hygiene." The Food Preparation and Service policy dated 4/19, indicated "Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use."	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		5/24/23

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F 883	Continued From page 57 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R10 and R32) admitted during the 2022/2023 influenza season (October 1 through March 31) received the influenza vaccination in accordance with the	F 883	R10 and R32 were offered the influenza vaccination for the 2022/2023 flu season and they declined. Like residents have the potential to be affected if this requirement is not met.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 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
F 883	Continued From page 58 Center for Disease Control (CDC) recommendations. Findings include: R10's face sheet dated 4/3/23, indicated R10 had been admitted to the facility in Jaunary 2023. R10's medical record lacked evidence of influenza immunization, education, contraindication, and/or documentation of refusal by the resident or resident representative. Vaccination status had been reviewd for R10 with current immunizations scanned in from Minnesota Immunization Information Connection (MIIC). After additional records were requested, the administrator provided a declination form signed by resident dated 4/3/23 after the start of the survey and after requested by the surveyor. R32's face sheet dated 4/3/23. Indicated R32 had been admitted to the facility in February 2023. R32's medical record lacked evidence of influenza immunization, education, contraindication, and/or documentation of refusal by the resident or resident representative. Vaccination status had been reviewd for R32 with current immunizations scanned in from Minnesota Immunization Information Connection (MIIC). After additional records were requested, the administrator provided declination form signed by resident dated 4/3/23 after the start of the survey and after requested by the surveyor. During interview on 4/5/23, at 9:02 a.m. infection preventionist (IP) stated vaccination status is reviewed upon intake with the completion of the admission MDS assessment. IP stated she is	F 883	All nursing staff have been re-educated to the requirement/regulation. Policy/Procedure was reviewed and remains appropriate. Resident immunizations will be reviewed/offered as appropriate upon admission and quarterly. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party.	

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	245459	A. BUILDING ______ B. WING ______	04/06/2023

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

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F 883	Continued From page 59 new to this role (starting 2/23) and hopes to have a process for ongoing surveillance and tracking of resident vaccines in place later this month. During interview on 4/6/23, at 8:45 a.m. director of nursing (DON) stated vaccinations are reviewed upon admission and again quarterly at the time of the MDS quarterly assessment. The facility Influenza and Influenza- Like Illness Policy dated 11/1/22 states "between October 1st and March 31st, residents will be offered the vaccine upon admission." "All residents will be interviewed upon admission and annually by the designated nurse to determine their influenza vaccination status. Consent for immunizations will be obtained upon admission." "A resident or staff's refusal of the vaccine (for reasons other than medical contraindication) will also be documented in the medical record."	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative	F 887		5/24/23

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	245459	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 887	Continued From page 60 receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National	F 887		

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	245459	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 887	Continued From page 61 Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R10, R25, and R32) reviewed for COVID-19 vaccination status were offered the COVID-19 vaccine, and/or provided education regarding the risks, benefits, and potential side effects of COVID-19 vaccinations in accordance the Centers for Disease Control and Prevention (CDC) recommendations. Findings include: R10's face sheet dated 4/3/23, indicated R10 had been admitted to the facility in January 2023. R10's medical record lacked evidence of COVID-19 vaccination, education, contraindication, and/or documentation of refusal by the resident or resident representative. Vaccination status had been reviewd for R10 with current immunizations scanned in from Minnesota Immunization Information Connection (MIIC). After Additional records were requested 4/3/23, the administrator provided declination form on 4/4/23 signed by resident and dated 4/3/23 after the survey enterance and after requested by the surveyor. R25's face sheet dated 4/3/23, indicated R10 had been admitted to the facility in March 2023. R25's medical record lacked evidence of COVID-19 vaccination, education, contraindication, and/or documentation of refusal by the resident or resident representative. Vaccination status had been reviewd for R25 with	F 887	R10, R25 and R32 were offered the COVID vaccination and they declined. Like residents have the potential to be affected if this requirement is not met. All nursing staff have been re-educated to the requirement/regulation. Residents immunizations will be reviewed/offered as appropriate upon admission and quarterly. Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for (4) weeks; and monthly thereafter for one (1) month. Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or designee is responsible party.	

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	245459	A. BUILDING ______ B. WING ______	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 887	Continued From page 62	F 887		

current immunizations scanned in from Minnesota Immunization Information Connection (MIIC). After Additional records were requested 4/3/23, the administrator provided declination form on 4/4/23 with verbal refusal from resident representative dated 4/3/23 after the survey enterance and after requested by the surveyor.

R32's face sheet dated 4/3/23. Indicated R32 had been admitted to the facility in February 2023.

R32's medical record lacked evidence of COVID-19 vaccination, education, contraindication, and/or documentation of refusal by the resident or resident representative. Vaccination status had been reviewd for R10 with current immunizations scanned in from Minnesota Immunization Information Connection (MIIC). After Additional records were requested 4/3/23, the administrator provided declination form on 4/4/23 signed by resident and dated 4/3/23 after the survey enterance and after requested by the surveyor.

During interview on 4/5/23, at 09:02 a.m. infection preventionist (IP) stated vaccination status is reviewed upon intake with the completion of the intake MDS assessment. IP stated she is new to this role (starting 2/23) and hopes to have a process for ongoing surveillance and tracking of resident vaccines in place later this month as there is not currently one in place.

During interview on 4/6/23, at 8:45 a.m. director of nursing (DON) stated vaccinations are reviewed upon intake and again quarterly at the time of the MDS quarterly assessment.

The facility COVID-19 Policy dated 3/13/23 states

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F 887	Continued From page 63 "prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the COVID vaccine." "Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated."	F 887		

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	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**04/04/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/04/2023. At the time of this survey, The Gardens of Winsted was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Gardens at Winsted consists of the original 1960 building. It is two-stories in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I(332) construction. In 2011, an addition was added and is a one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.