*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 23, 2024

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

RE: CCN: 245459
Cycle Start Date: February 7, 2024

Dear Administrator:

On February 7, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 May 7, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 7, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245459 | A. BUILDING ______ B. WING ______ | C 02/07/2024 |

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

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| E 000 | Initial Comments<br><br>On 2/5/24 through 2/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 041 SS=F | Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.<br><br>§483.73(e), §485.625(e), §485.542(e)<br>(e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.542(e)(1), | E 041 | | 2/29/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/03/2024

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

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| E 041 | Continued From page 1<br>§485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the | E 041 | | |

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| E 041 | Continued From page 2<br>material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. | E 041 | | |

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| E 041 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/06/2024 at 11:18 AM, it was revealed by observation that there was a red low-voltage wire wrapped around a sprinkler pipe above the ceiling outside of the nurse managers office.<br><br>An interview with the Maintenance Director and Maintenance Assistant verified this deficient finding at the time of discovery. | E 041 | "An area for improvement was identified when, upon document review, there was no evidence to support the facility completed a 4-hour load bank test in the past 36 months.<br>"Failure to meet this requirement has the potential to have a widespread impact on residents within the facility.<br>"The Maintenance Director has been educated to the requirement and the identified area of concern has been corrected.<br>"An approved vendor was on-site on 2/12/2024 and completed the 4-hour load bank test.<br>"Corrective action was completed and the requirement is met for 36 months.<br>"Corrective action will be reviewed at QAPI with any area of concern immediately addressed.<br>"Maintenance Director or designee is responsible party.<br>"Corrective action was completed on 2/29/2024. | |
| F 000 | INITIAL COMMENTS<br><br>On 2/5/24 through 2/7/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO deficiencies cited:<br>H54599257C/MN00096477 | F 000 | | |

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| F 000 | Continued From page 4<br>H54599584C/MN00010058<br>H54599493C/MN00010057<br><br>The following complaints were reviewed:<br>H54599357C/MN00098761 with a deficiency cited at F760.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 580<br>SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(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);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to | F 580 | | 3/4/24 |

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| F 580 | Continued From page 5<br>commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>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 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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 resident's (R42) reviewed for new onset of hallucinations and delusions. | F 580 | "Physician was updated regarding R42s condition. R42 was discharged from facility.<br>"All residents have the potential to be affected if this requirement is not met.<br>"Necessary staff have been re-educated | |

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| F 580 | Continued From page 6<br>Findings include:<br><br>R42's admission minimum data set (MDS) dated 12/18/23, identified severe impairment in cognition with no hallucinations or delusions and diagnoses of myocardial infarction (heart attack), heart failure, gastrointestinal hemorrhage, and anemia.<br><br>Hospital discharge orders dated 12/11/23, indicated resident was hospitalized related to confusion and condition was improving. Therapy orders for occupational, physical therapy and rehabilitation potential was good.<br><br>Care plan dated 12/12/23, instructed staff to monitor for lethargy and increased confusion.<br><br>Progress note dated 12/11/23 at 5:55 p.m., identified R42 admitted to the facility with a discharge plan to return home after therapies.<br><br>Progress note dated 12/11/23 at 10:18 p.m., indicated R42 was hard to arouse and slept all shift.<br><br>Progress note dated 12/13/23 at 6:43 p.m., indicated R42 wandered in the facility hallway looking for spouse. The record lacked evidence of notification to the attending physician.<br><br>Progress note dated 12/14/23 at 11:56 a.m., identified staff had spoken with R42's daughter. She stated R42's confusion had gotten worse over the last one to two months with no current diagnosis for impaired cognition.<br><br>Progress note dated 12/16/23 at 2:55 a.m., indicated R42 had been wandering in the facility | F 580 | to the requirement/regulation.<br>"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.<br>"Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence.<br>"Director of Nursing or designee is responsible party.<br>"Corrective action was completed on or before 3/3/2024. | |

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| F 580 | Continued From page 7 | F 580 | | |

hallways and had claimed to see a cat stuck outside the doors. The record lacked evidence of notification to the attending physician.

R42's attending physician visit summary dated 12/18/23, identified forgetfulness and confusion with no note regarding potential hallucinations, delusions or wandering.

Progress note dated 12/19/23 at 11:35 p.m., indicated R42 had a decreased appetite, sleeping difficulties, easily agitated and hard to redirect with delusions of her children being dead. The record lacked evidence the attending physician had been notified.

Progress note dated 12/21/23 at 11:09 p.m., indicated R42 refused meals, had sleeping difficulties, was resistant to cares, and wandered. R42 packed personal items, and spouse was coming to pick resident up. The record lacked evidence of notification to the attending physician.

Progress note dated 12/22/23 at 12:06 p.m., indicated R42's had garbled/mumbled speech, irregular pulse, increased edema to lower extremities, shortness of breath with exertion, decreased appetite and decreased fluid intake. The progress note also identified R42's hallucinations and delusions included seeing spiders all over her room, three kittens in the window, strangers in her room, and people dancing in the courtyard outside her room. Further, R42 had been screaming out in her sleep. The record lacked evidence the attending physician had been notified.

Progress note dated 12/23/23 at 7:21 p.m., indicated R42 hallucinated and had delusions

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| F 580 | Continued From page 8 | F 580 | | |

regarding spouse wanting a divorce, seeing cats and spiders all over her room. The record lacked evidence the attending physician was notified.

Progress note dated 12/24/23 at 12:31 p.m., indicated R42 was restless, fidgety and hallucinated about cats and spiders. R42 had slept for approximately an hour and woke up screaming about spiders crawling all over her. The record lacked evidence the attending physician was notified.

Progress note dated 12/26/23 at 3:30 p.m., indicated R42 remained in bed for the entire shift and refused all medications. The record lacked evidence the attending physician had been notified.

Progress note dated 12/27/23 at 4:33 a.m., identified R42 had been found by staff unresponsive, gasping and below normal vital signs. 911 was called. The progress note indicated R42's daughter wanted her sent to the ER. The progress notes later indicated R42 was sent to the hospital where she expired.

When interviewed on 2/7/24 at 5:43 p.m., the director of nursing (DON) stated R42's onset of hallucinations, lethargy and decrease appetite could have represented a change in condition for which the attending physician should have been notified. The DON stated the importance of updating the attending physician of changes in condition was to enable them to make decisions on or changes to the resident's plan of care.

When interviewed on 2/12/24 at 8:56 a.m., R42's attending provider nurse practitioner (NP)-K stated resident had baseline confusion and

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| F 580 | Continued From page 9<br>delirium with previous hospitalizations over the previous two months prior to admissio to facility and was very frail. NP-K stated she saw R42 for the first time on 12/18/23 and noted her to be confused. On 12/19/23, NP-K was notified R42 had difficulty sleeping and ordered Melatonin. On 12/19/23, the facility requested a diagnosis of impaired cognition. On 12/21/23, the facility requested transfer/ discharge orders for placement in another nursing home where R42's husband resided. On 12/22/23, NP-K was notified R42 had a new wound to her heel.<br><br>NP-K stated she was not made aware of R42's hallucinations, delusions, distress, decreasing appetite, increasing edema, shortness of breath or irregular pulse. NP-K would have considered these to be a change in condition. NP-K stated her expectation was for her or the on-call provider to be notified of changes in condition. Had she been made aware, NP-K would have ordered labs, possibly a nutritional supplement and discussed additional medications with the family or have ordered resident to be transferred to the emergency room for evaluation. NP-K stated she did not believe this would have prevented her overall decline and had not expected a good outcome related to her frailty and health conditions, although interventions could have made R42 more comfortable and facilitated palliative care discussions with the family.<br><br>The facility undated policy Change in a Resident's Condition or Status, identified staff will notify the resident's attending physician or physician on call when there is a significant change in the resident's physical/emotional or mental condition. | F 580 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance | F 692 | | 3/4/24 |

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| F 692 | Continued From page 10<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§483.25(g)(1) Maintains acceptable parameters 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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to follow the interventions for 1 of 1 residents (R34) reviewed for weight loss and nutrition leading to a 15 lbs (8.37%) weight loss over the course of 47 days.<br><br>Findings include:<br><br>R34's admission record dated 12/26/2023, indicated medical diagnoses of vascular dementia, severe with agitation; anxiety disorder; moderate protein calorie malnutrition.<br><br>R34's admission weight was noted to be 125.5 | F 692 | "R34s care plan was reviewed and appropriate interventions were implemented to assist with weight loss interventions.<br>"All residents have the potential to be affected.<br>"Necessary staff have been re-educated to the requirement/regulation.<br>"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.<br>"Audits will be reviewed at QAPI and any deficient practice will be identified and | |

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| F 692 | Continued From page 11<br>lbs. on 12/16/23. R34's weight on 1/31/24 was 115 lbs., indicating an 8.37% weight loss over the course of 47 days.<br><br>R34's care plan listed potential for altered nutrition status related to need for mechanically altered diet related to dysphagia; and Potential for weight loss related to altered oral intakes as evidenced by malnutrition diagnosis. Interventions indicated R34 needed staff assistance with eating and drinking.<br>R34's record of meal intake indicated resident refused or had eaten less than 25 % of her meal for 62 out of 100 meals served from 12/26/23 through 2/7/2024.<br><br>During observation on 2/5/24 at 5:22 p.m., R34 was seated in the dining room in her wheelchair and pushed up to a table. On the table directly in front of her was a bowl with a ground yellowish gray substance. To the right of the bowl was a spoon. R34 made no attempt to lift spoon or feed herself. No staff assisted her to eat.<br><br>During observation on 2/6/24 at 12:19 p.m., R34 was seated in the dining room in her wheelchair and pushed up to a table. Staff brought a glass of clear liquid and set it in front of her. Staff brought a bowl of reddish-brown pureed substance, a bowl of whitish yellow pureed substance, a bowl of thick orange pureed substance and a bowl of dark green pureed substance. The menu indicated the meal served was country style ribs and kraut, sweet potatoes, and broccoli florets. R34 made no attempt to feed herself and staff made no offer or attempts to assist resident.<br><br>During continuous observation on 2/07/24 from 08:37 a.m. through 09:10 a.m. R34 was seated | F 692 | corrected at the time of occurrence.<br>"Director of Nursing or designee is responsible party.<br>"Corrective action was completed on or before 3/3/2024. | |

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| F 692 | Continued From page 12 | F 692 | | |

in dining room in wheelchair; dressed; hands clenched in lap, head tilted down and to the left; clothing protector lying on table. At 08:40 a.m., utensils and food was placed front of R34. At 08:44 a.m., resident continued to sit at table with head down; no attempts made to feed self. At 08:49 a.m., no attempts being made to feed self; At 08:54 a.m., staff had not attempted or encouraged resident to eat; resident continued to have head hanging down towards the left; hands in lap. At 08:58 a.m., resident lifted head for a moment, looked at food, and put head back down; made no attempts to feed self; At 09:02 a.m., staff assisted another resident at same table; continued to not assist R34; R34 backed away from table; staff walked by and said hello to R34. At 09:04 a.m., staff approached R34, and she indicated she was finished and wanted to leave the table; Staff walked away without assisting R34. At 09:10 a.m., no attempts made to eat or be assisted to eat. At 09:16 a.m., staff assisted R34 to pull away from table. R34 ate zero % of meal.

Interview with Certified Nursing Assistant (CNA)-A on 02/07/2024 at 0915 a.m., during interview CNA stated the tickets informed staff who needed help or ask the nurse. The chart also indicated resident needs. It meant staff needed to help residents, sit next to them, and assist them to eat. Staff stated she assisted residents by either guiding their hand to their mouth or feeding them.

During interview on 02/07/2024 at 09:22 a.m., CNA-B stated residents' meal ticket from the kitchen or the information from the nurse indicated who required help. When it indicated assistance staff were to guide residents' hands, placing utensil, and/or indicate where food was

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| F 692 | Continued From page 13<br>located on the plate.<br><br>During interview on 02/07/2024 at 0933 a.m., RN (Registered nurse) A stated staff referred to the care plan to identify residents that required assistance. Culinary staff indicated required assistance on individual meal tickets. Residents chart also indicated required assistance. Staff were notified in change of resident status in report. RN-A stated her expectation was staff sat near residents to hand them food or prompt them to eat. When residents required a pureed diet staff were expected to use hand over hand or feed residents.<br><br>During interview on 02/07/2024 at 0950 a.m., with Licensed practical nurse (LPN) A stated staff were altered to resident requiring assistance by looking at the care plan, the meal ticket or the resident chart.<br><br>During interview on 02/07/2024 at 10:20 a.m., Director of Nursing (DON) stated residents need for assistance was indicated on the care plan, on their group sheets, and dietary tickets. Care sheets were updated every other day. When there was a decline in weight, staff meets to review. When a physical decline was indicated a supplement was initiated, monitored for refusal, and weights were recorded. It was important to assist residents when required to avoid a decline in weight. | F 692 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors. | F 760 | | 3/4/24 |

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| F 760 | Continued From page 14<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 (R94), residents reviewed for medication orders and administration.<br><br>Findings include:<br><br>R94's admission minimum data set (MDS) dated 9/21/23, identified intact cognition, diagnoses of manic depression, bi-polar, and antipsychotic medication. Admitted to the facility 9/15/23 for short term therapy following hospitalization for bi-lateral pulmonary embolisms and falls.<br><br>R94's hospital discharge orders dated 9/15/23, identified an order for aripiprazole (an antipsychotic medication) 30 milligrams (mg) take 30 mg by mouth once daily for manic depression.<br><br>R94's facility discharge order summary report dated 11/14/23 identified an order for aripiprazole give 30 mg by mouth two times a day (bid) related to major depressive disorder with a start date of 9/15/23. This dose is double the order identified in R94's hospital discharge orders.<br><br>R94's medication administration records identified administration of aripiprazole 30 mg bid from admit 9/15/23 through discharge 11/17/23 resulting in a double dose sixty-two out of the sixty-four days of resident's stay.<br><br>R94's consultant pharmacist medication regimen review dated 9/28/23, identified resident's ordered medications trazadone (an antidepressant) 300 mg every bedtime, aripiprazole 30 mg bid as a | F 760 | "R94 discharged from facility.<br>"All residents have the potential to be affected.<br>"Necessary staff have been re-educated to the requirement/regulation.<br>"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.<br>"Audits will be reviewed at QAPI and any deficient practice will be identified and corrected at the time of occurrence.<br>"Director of Nursing or designee is responsible party.<br>"Corrective action was completed on or before 3/3/2024. | |

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| F 760 | Continued From page 15 | F 760 | | |

"higher dose", baclofen (a muscle relaxer) when necessary, Prozac (an antidepressant) 40 mg every day, tetrabenazine (a drug used to treat involuntary movements) 100 mg every day, gabapentin (an anticonvulsant and nerve pain medication) and buprenorphine a narcotic. The medication regimen review indicated the aripiprazole dose, in combination with resident's other medications increased the risk of falls and fractures. The medication regimen review also asked the attending physician to assess the risk versus benefit and consider reducing any of these medications. The attending physician response signed 9/29/23 stated disagreement with the recommendation and that a gradual dose reduction would be started soon as R94 was a new admit to the facility.

When interviewed on 2/7/24 at 11:38 a.m., R94's foster care provider (FCP)-E stated when resident was discharged from the facility back to her care in the foster home, she noticed her order for aripiprazole was incorrect on the medication card and discharge orders from the facility. The FCP-E stated normally R94 took aripiprazole 30 mg once a day as ordered by her community psychiatrist and this dose was most effective for resident's mental illness diagnoses. The FCP-E stated she gave R94 the previously ordered 30 mg and contacted her community psychiatrist to ensure correct dose. The FCP-E stated the first few days after returning to the foster home, R94 was more sleepy than usual and had a decreased appetite with some drooling. FCP thought it was related to her recent health issues and being in the facility in therapies.

When interviewed on 2/7/24 at 1:09 p.m., registered nurse (RN)-A stated the facility health

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unit coordinator (HUC) entered orders upon admission and a licensed nurse did a second check to ensure accuracy. After reviewing R94's admission orders, RN-A stated she had entered R94's orders. She couldn't recall if any other staff had performed a second check. RN-A confirmed R94 received aripiprazole 30 mg bid throughout the course of her stay. It was entered incorrectly resulting in a double daily dose.

When interviewed on 2/7/24 at 3:55 p.m., R94's attending physician and facility medical director (MD)-C stated receiving double the ordered dose for sixty-two days of aripiprazole would constitute a significant medication error and had she been aware the correct dose was for once a day she would have reduced the medication per the pharm-D recommendation on 9/28/23. The MD stated she did not believe the medication error harmed R94 as resident made progress in therapies, had no noted drooling, lethargy, and no increased involuntary movements. The MD stated her expectation for the facility was orders were reviewed by two licensed nurses.

When interviewed on 2/7/24 at 4:40 p.m., the facility consulting pharmacist (Pharm-D) stated the high dose of R94's aripiprazole in conjunctions with her other medications could lead to increased risk of falls and fractures.

When interviewed on 2/7/24 at 1:26 p.m., the director of nursing (DON) stated the facility admission order entry process was part of the admissions checklist for a licensed nursed or health unit coordinator to enter orders and a second check should be done by a licensed nurse. The DON stated this process was important to avoid mistakes that could result in

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| F 760 | Continued From page 17<br>resident harm. The DON confirmed R94's aripiprazole order was entered incorrectly upon admission resulting in a double dose throughout her stay.<br><br>An admission order entry policy was requested but not received. The undated admissions checklist includes a section regarding orders instructed staff to enter orders and a second check to be done by a nurse. | F 760 | | |
| F 851 SS=F | Payroll Based Journal<br>CFR(s): 483.70(q)(1)-(5)<br><br>§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.<br>Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.<br><br>§483.70(q)(1) Direct Care Staff.<br>Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).<br><br>§483.70(q)(2) Submission requirements.<br>The facility must electronically submit to CMS complete and accurate direct care staffing | F 851 | | 3/4/24 |

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| F 851 | Continued From page 18<br>information, including the following:<br>(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);<br>(ii) Resident census data; and<br>(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).<br><br>§483.70(q)(3) Distinguishing employee from agency and contract staff.<br>When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.<br><br>§483.70(q)(4) Data format.<br>The facility must submit direct care staffing information in the uniform format specified by CMS.<br><br>§483.70(q)(5) Submission schedule.<br>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information at least quarterly or more often, including information for agency and contract staff, based on payroll and other | F 851 | "The process for satisfying this requirement has been review and revised as needed to ensure the facility submits to CMS complete and accurate direct care staffing information quarterly. | |

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| F 851 | Continued From page 19<br>verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 4) in Federal Fiscal Year 2023, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This has the potential to affect all 42 residents residing in the facility.<br><br>Findings include:<br><br>CMS PBJ Staffing Report for Fiscal Year 2023 Quarter 4 (July 1-September 30) results listed Excessively Low Weekend Staffing as triggered due to data submitted by the facility to CMS. Review of daily staff postings for this time period, which listed the number of staff and total hours worked was not found to be drastically different on the weekends versus the weekdays. Census for this time priod was also compared and not found to fluctuate significantly.<br><br>During interview on 2/7/24 at 1:48 p.m., Staffing Coordinator (SC)-H stated staffing needs were determined based on resident acuity and census. These needs were determined on a daily basis Monday through Friday. Level of staffing on the weekends was the same as the weekdays.<br><br>During interview on 2/7/24 at 2:03 p.m., Human Resources (HR)- G stated submitted data does include the hours worked by agency staff and facility staff.<br><br>During interview on 2/7/24 at 2:12 p.m., Administrator- F- stated Human Resources Director submits the data for payroll based journal.<br><br>A facility policy was requested and was not received. | F 851 | "This had the potential to affect all residents, staff, and visitors.<br>"The facility will submit complete and accurate PBJ data in future quarters.<br>"Necessary staff at The Gardens at Winsted have been re-educated to the requirement and regulation utilizing the CMS submission guide and Monarch Healthcare Management PBJ Submission guide.<br>"Compliance audits will be completed at the time of PBJ filings/submissions. The expectation is to complete quarterly for two (2) quarters and review results at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.<br>"Administrator or designee is responsible party.<br>"Compliance will be achieved on or before 3/3/2024. | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 23, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: SSJV11

Dear Administrator:

The above facility was surveyed on February 5, 2024 through February 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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| 2 000 | Initial Comments | 2 000 | | |

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 2/5/24 through 2/7/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed during the survey and NO licensing orders were issued:<br>H54599257C/MN00096477<br>H54599357C/MN00098761<br>H54599584C/MN00010058<br>H54599493C/MN00010057<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the | 2 000 | | |

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| 2 000 | Continued From page 2<br>Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 265 | MN Rule 4658.0085 Notification of Chg in Resident Health Status<br><br>A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:<br><br>A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; | 2 265 | | 3/4/24 |

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C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 resident's (R42) reviewed for new onset of hallucinations and delusions.

Corrected

Findings include:

R42's admission minimum data set (MDS) dated 12/18/23, identified severe impairment in cognition with no hallucinations or delusions and diagnoses of myocardial infarction (heart attack), heart failure, gastrointestinal hemorrhage, and anemia.

Hospital discharge orders dated 12/11/23, indicated resident was hospitalized related to confusion and condition was improving. Therapy orders for occupational, physical therapy and rehabilitation potential was good.

Care plan dated 12/12/23, instructed staff to monitor for lethargy and increased confusion.

Progress note dated 12/11/23 at 5:55 p.m., identified R42 admitted to the facility with a

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discharge plan to return home after therapies.

Progress note dated 12/11/23 at 10:18 p.m., indicated R42 was hard to arouse and slept all shift.

Progress note dated 12/13/23 at 6:43 p.m., indicated R42 wandered in the facility hallway looking for spouse. The record lacked evidence of notification to the attending physician.

Progress note dated 12/14/23 at 11:56 a.m., identified staff had spoken with R42's daughter. She stated R42's confusion had gotten worse over the last one to two months with no current diagnosis for impaired cognition.

Progress note dated 12/16/23 at 2:55 a.m., indicated R42 had been wandering in the facility hallways and had claimed to see a cat stuck outside the doors. The record lacked evidence of notification to the attending physician.

R42's attending physician visit summary dated 12/18/23, identified forgetfulness and confusion with no note regarding potential hallucinations, delusions or wandering.

Progress note dated 12/19/23 at 11:35 p.m., indicated R42 had a decreased appetite, sleeping difficulties, easily agitated and hard to redirect with delusions of her children being dead. The record lacked evidence the attending physician had been notified.

Progress note dated 12/21/23 at 11:09 p.m., indicated R42 refused meals, had sleeping difficulties, was resistant to cares, and wandered. R42 packed personal items, and spouse was coming to pick resident up. The record lacked

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evidence of notification to the attending physician.

Progress note dated 12/22/23 at 12:06 p.m., indicated R42's had garbled/mumbled speech, irregular pulse, increased edema to lower extremities, shortness of breath with exertion, decreased appetite and decreased fluid intake. The progress note also identified R42's hallucinations and delusions included seeing spiders all over her room, three kittens in the window, strangers in her room, and people dancing in the courtyard outside her room. Further, R42 had been screaming out in her sleep. The record lacked evidence the attending physician had been notified.

Progress note dated 12/23/23 at 7:21 p.m., indicated R42 hallucinated and had delusions regarding spouse wanting a divorce, seeing cats and spiders all over her room. The record lacked evidence the attending physician was notified.

Progress note dated 12/24/23 at 12:31 p.m., indicated R42 was restless, fidgety and hallucinated about cats and spiders. R42 had slept for approximately an hour and woke up screaming about spiders crawling all over her. The record lacked evidence the attending physician was notified.

Progress note dated 12/26/23 at 3:30 p.m., indicated R42 remained in bed for the entire shift and refused all medications. The record lacked evidence the attending physician had been notified.

Progress note dated 12/27/23 at 4:33 a.m., identified R42 had been found by staff unresponsive, gasping and below normal vital signs. 911 was called. The progress note

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indicated R42's daughter wanted her sent to the ER. The progress notes later indicated R42 was sent to the hospital where she expired.

When interviewed on 2/7/24 at 5:43 p.m., the director of nursing (DON) stated R42's onset of hallucinations, lethargy and decrease appetite could have represented a change in condition for which the attending physician should have been notified. The DON stated the importance of updating the attending physician of changes in condition was to enable them to make decisions on or changes to the resident's plan of care.

When interviewed on 2/12/24 at 8:56 a.m., R42's attending provider nurse practitioner (NP)-K stated resident had baseline confusion and delirium with previous hospitalizations over the previous two months prior to admissio to facility and was very frail. NP-K stated she saw R42 for the first time on 12/18/23 and noted her to be confused. On 12/19/23, NP-K was notified R42 had difficulty sleeping and ordered Melatonin. On 12/19/23, the facility requested a diagnosis of impaired cognition. On 12/21/23, the facility requested transfer/ discharge orders for placement in another nursing home where R42's husband resided. On 12/22/23, NP-K was notified R42 had a new wound to her heel.

NP-K stated she was not made aware of R42's hallucinations, delusions, distress, decreasing appetite, increasing edema, shortness of breath or irregular pulse. NP-K would have considered these to be a change in condition. NP-K stated her expectation was for her or the on-call provider to be notified of changes in condition. Had she been made aware, NP-K would have ordered labs, possibly a nutritional supplement and discussed additional medications with the family

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| 2 265 | Continued From page 7<br>or have ordered resident to be transferred to the emergency room for evaluation. NP-K stated she did not believe this would have prevented her overall decline and had not expected a good outcome related to her frailty and health conditions, although interventions could have made R42 more comfortable and facilitated palliative care discussions with the family.<br><br>The facility undated policy Change in a Resident's Condition or Status, identified staff will notify the resident's attending physician or physician on call when there is a significant change in the resident's physical/emotional or mental condition.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could review and revise policies and procedures for changes in condition and provider notifications. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure provider notifications of changes in condition.. The quality assurance committee could monitor these measures to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 2 265 | | |
| 21545 | MN Rule 4658.1320 A.B.C Medication Errors<br><br>A nursing home must ensure that:<br>A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For | 21545 | | 3/4/24 |

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| 21545 | Continued From page 8<br>purposes of this part, a medication error means:<br>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or<br>(2) the administration of expired medications.<br>B. It is free of any significant medication error. A significant medication error is:<br>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or<br>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br>C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the | 21545 | Corrected | |

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| 21545 | Continued From page 9<br>facility failed to ensure residents were free of significant medication errors for 1 of 1 (R94), residents reviewed for medication orders and administration.<br><br>Findings include:<br><br>R94's admission minimum data set (MDS) dated 9/21/23, identified intact cognition, diagnoses of manic depression, bi-polar, and antipsychotic medication. Admitted to the facility 9/15/23 for short term therapy following hospitalization for bi-lateral pulmonary embolisms and falls.<br><br>R94's hospital discharge orders dated 9/15/23, identified an order for aripiprazole (an antipsychotic medication) 30 milligrams (mg) take 30 mg by mouth once daily for manic depression.<br><br>R94's facility discharge order summary report dated 11/14/23 identified an order for aripiprazole give 30 mg by mouth two times a day (bid) related to major depressive disorder with a start date of 9/15/23. This dose is double the order identified in R94's hospital discharge orders.<br><br>R94's medication administration records identified administration of aripiprazole 30 mg bid from admit 9/15/23 through discharge 11/17/23 resulting in a double dose sixty-two out of the sixty-four days of resident's stay.<br><br>R94's consultant pharmacist medication regimen review dated 9/28/23, identified resident's ordered medications trazadone (an antidepressant) 300 mg every bedtime, aripiprazole 30 mg bid as a "higher dose", baclofen (a muscle relaxer) when necessary, Prozac (an antidepressant) 40 mg every day, tetrabenazine (a drug used to treat involuntary movements) 100 mg every day, | 21545 | | |

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gabapentin (an anticonvulsant and nerve pain medication) and buprenorphine a narcotic. The medication regimen review indicated the aripiprazole dose, in combination with resident's other medications increased the risk of falls and fractures. The medication regimen review also asked the attending physician to assess the risk versus benefit and consider reducing any of these medications. The attending physician response signed 9/29/23 stated disagreement with the recommendation and that a gradual dose reduction would be started soon as R94 was a new admit to the facility.

When interviewed on 2/7/24 at 11:38 a.m., R94's foster care provider (FCP)-E stated when resident was discharged from the facility back to her care in the foster home, she noticed her order for aripiprazole was incorrect on the medication card and discharge orders from the facility. The FCP-E stated normally R94 took aripiprazole 30 mg once a day as ordered by her community psychiatrist and this dose was most effective for resident's mental illness diagnoses. The FCP-E stated she gave R94 the previously ordered 30 mg and contacted her community psychiatrist to ensure correct dose. The FCP-E stated the first few days after returning to the foster home, R94 was more sleepy than usual and had a decreased appetite with some drooling. FCP thought it was related to her recent health issues and being in the facility in therapies.

When interviewed on 2/7/24 at 1:09 p.m., registered nurse (RN)-A stated the facility health unit coordinator (HUC) entered orders upon admission and a licensed nurse did a second check to ensure accuracy. After reviewing R94's admission orders, RN-A stated she had entered R94's orders. She couldn't recall if any other staff

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|---|---|---|---|
| | 00352 | A. BUILDING: ______ B. WING ______ | C 02/07/2024 |

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

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| 21545 | Continued From page 11 | 21545 | | |

had performed a second check. RN-A confirmed R94 received aripiprazole 30 mg bid throughout the course of her stay. It was entered incorrectly resulting in a double daily dose.

When interviewed on 2/7/24 at 3:55 p.m., R94's attending physician and facility medical director (MD)-C stated receiving double the ordered dose for sixty-two days of aripiprazole would constitute a significant medication error and had she been aware the correct dose was for once a day she would have reduced the medication per the pharm-D recommendation on 9/28/23. The MD stated she did not believe the medication error harmed R94 as resident made progress in therapies, had no noted drooling, lethargy, and no increased involuntary movements. The MD stated her expectation for the facility was orders were reviewed by two licensed nurses.

When interviewed on 2/7/24 at 4:40 p.m., the facility consulting pharmacist (Pharm-D) stated the high dose of R94's aripiprazole in conjunctions with her other medications could lead to increased risk of falls and fractures.

When interviewed on 2/7/24 at 1:26 p.m., the director of nursing (DON) stated the facility admission order entry process was part of the admissions checklist for a licensed nursed or health unit coordinator to enter orders and a second check should be done by a licensed nurse. The DON stated this process was important to avoid mistakes that could result in resident harm. The DON confirmed R94's aripiprazole order was entered incorrectly upon admission resulting in a double dose throughout her stay.

An admission order entry policy was requested

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| 21545 | Continued From page 12<br><br>but not received. The undated admissions checklist includes a section regarding orders instructed staff to enter orders and a second check to be done by a nurse.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 21545 | | |

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| | 245459 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ____________ | **02/06/2024** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/06/2024. At the time of this survey, The Gardens At Winsted was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/03/2024 |

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

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>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. | K 000 | | |

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| K 000 | Continued From page 2<br><br>The facility has a capacity of 70 beds and had a census of 40 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 353<br>SS=B | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_______________<br>b) Who provided system test<br>____________________<br>c) Water system supply source<br>__________________<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection | K 353 | "The red low-voltage wire that was wrapped around a sprinkler pipe above the ceiling outside of the nurse managers office was relocated.<br>"This finding could have the potential to have a patterned impact on the residents | 2/29/24 |

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| K 353 | Continued From page 3<br>Systems, section 5.2.2.2. This deficient finding could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/06/2024 at 11:18 AM, it was revealed by observation that there was a red low-voltage wire wrapped around a sprinkler pipe above the ceiling outside of the nurse managers office.<br><br>An interview with the Maintenance Director and Maintenance Assistant verified this deficient finding at the time of discovery. | K 353 | within the facility.<br>"The Maintenance Director has been educated to the requirement and the identified area of concern has been corrected.<br>"An approved vendor was on-site on 2/12/2024 and relocated the red-wire to an appropriate location.<br>"Corrective action was completed.<br>"Corrective action will be reviewed at QAPI with any area of concern immediately addressed.<br>"Maintenance Director or designee is the responsible party.<br>"Corrective action was completed on 2/29/2024. | |
| K 918<br>SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of | K 918 | | 2/29/24 |

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| K 918 | Continued From page 4<br>stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, 8.4.9.2, 8.4.9.5.3, and 8.4.9.7. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/06/2024 between 09:45 AM and 12:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load bank test has been completed within the last 36 months on the emergency generator.<br><br>An interview with the Maintenance Director and | K 918 | "An area for improvement was identified when, upon document review, there was no evidence to support the facility completed a 4-hour load bank test in the past 36 months.<br>"Failure to meet this requirement has the potential to have a widespread impact on residents within the facility.<br>"The Maintenance Director has been educated to the requirement and the identified area of concern has been corrected.<br>"An approved vendor was on-site on 2/12/2024 and completed the 4-hour load bank test.<br>"Corrective action was completed and the requirement is met for 36 months.<br>"Corrective action will be reviewed at QAPI with any area of concern immediately addressed.<br>"Maintenance Director or designee is responsible party. | |

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| K 918 | Continued From page 5<br>Maintenance Assistant verified this deficient finding at the time of discovery. | K 918 | "Corrective action was completed on 2/29/2024. | |