DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 8, 2022

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

RE: CCN: 245459
Cycle Start Date: May 6, 2022

Dear Administrator:

On May 20, 2022, we notified you a remedy was imposed. On July 1, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 4, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 20, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 4, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 30, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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July 8, 2022

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

Re: Reinspection Results
Event ID: Z7KH12

Dear Administrator:

On July 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 6, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 20, 2022

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

RE: CCN: 245459
Cycle Start Date: May 6, 2022

Dear Administrator:

On May 6, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 4, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 4, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 4, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 4, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Gardens At Winsted Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 4, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 6, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	245459	A. BUILDING _____ B. WING _____	C 05/06/2022

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
E 000	Initial Comments On 5/2/22 through 5/6/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS Revised 2567 as a result of an Informal Dispute Resolution. On 5/2/2022-5/6/2022, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5459073C (MN 00083041) H5459076C (MN 00081549) H5459074C (MN 00078157) H54591140C (MN 00083088) However NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints was found to be unsubstantiated: H54591105C (MN00083117) and H5459075C (MN 00082135).	F 000		

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

Electronically Signed | 05/30/2022

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to inform a responsible party in	F 552	- R13□s Responsible Party was informed of the risk and benefits of psychotropic	6/30/22

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F 552	Continued From page 2 advance, of the risks and benefits and receive consent of proposed care for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13's significant change Minimum Data Set (MDS) dated 2/9/22, indicated severe cognitive impairment and a diagnosis of vascular dementia with behavioral disturbance. Emergency Room Visit Summary dated 4/4/22, indicated an order to start haloperidol (an antipsychotic medication with a black box warning of increased risk of death when given to elderly patients with dementia) 2 mg/mL, take 2.5 ml (5 mg) by mouth twice a day for 7 days. However, an Informed Consent for Required Medications indicating possible risks/side effects was not provided to the responsible party for haloperidol 2 mg/ml. Physician Orders indicated an order dated 4/26/22, for scheduled haloperidol lactate concentrate 2 mg/ml, give 2.5 mg by mouth one time daily. However, an informed consent indicating possible risks/side effects was not provided to the responsible party for haloperidol 2 mg/ml. On 5/6/22, at 4:37 p.m. the administrator acknowledged that an informed consent was not, but should have been, obtained from the responsible party for haloperidol 2 mg/ml. The facility's Psychotropic Medication Use policy, undated, indicated informed consent including effects and potential side effects will be obtained from resident and/or responsible party for each	F 552	medications. - All residents who receive psychotropic medications have the potential to be affected if this requirement is not met. - All necessary 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 four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 6/30/2022.	

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F 552	Continued From page 3 psychotropic medication.	F 552		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine bathing/showering assistance for 1 of 5 residents (R39) reviewed for activities of daily living who required assistance with bathing. Findings include: R39's annual Minimum Data Set (MDS) dated 4/6/22, indicated R39 was cognitively intact. Section G of the MDS indicated R39's bathing had not occurred during the look back period of 7 days. R39's care plan dated 2/12/21, indicated R39 required assistance of one for physical help in part of bathing activity. When interviewed on 5/2/22, at 1:48 p.m. R39 sated, "I would just like to have a bath," and indicated that she had not been getting a bath weekly which is, "aggravating," resident further stated "This is my home, I should be able to have a bath" Review of R39's orders identified order dated 5/31/20, weekly skin inspection by licensed nurse, ensure shower is completed every Sunday, prefers shower around 9:45 a.m.	F 677	-The process for satisfying this requirement has been reviewed and revised as needed to ensure qualified GAW staff provide routine bathing / showering assistance to appropriate residents. -Residents residing in this facility who are dependent upon qualified GAW staff to be bathed/showered have the potential to be affected if this regulation is not met. -R39 was immediately bathed/showered.. -Education will be provided using Monarch Healthcare Management Policy and Procedure to any qualified GAW staff who provide ADL cares to dependent residents. - Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 6/30/2022.	6/30/22

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F 677	Continued From page 4 R39's Point of Care (POC) Follow Up Question Report for March 2022, indicated staff should have assisted R39 with a shower on 3/6/22, 3/13/22, 3/20/22 and 3/27/22. However, the bathing was not signed off as being provided on 3/9/22, 3/13/22, or 3/27/22. R39's POC Follow Up Question Report for April 2022, R39 was to have bathing completed on 4/3/22, 4/10/22, 4/17/22 and 4/24/22. However, the bathing was not signed off as being provided on 4/3/22 or 4/10/22. When interviewed on 5/5/22, at 1:25 p.m. nursing assistant (NA)-A stated R39 never refuses a shower. Staffing could be difficult at times, there was no problem completing resident cares. During interview on 5/5/22, at 1:30 p.m. NA-C voiced R39 never refused bathing, stating she's the one that kept them on top of things. When interviewed on 5/6/22, at 3:39 p.m. clinical manager (CM)-A stated R39 does not refuse her shower, there had just been an in-service regarding showers and cares. CM-A stated it was unacceptable to not get showers done. A policy regarding bathing was requested, however, none was provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		6/30/22

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F 684	Continued From page 5 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement orders for compression therapy for 1 of 1 residents (R21) reviewed with non-pressure skin conditions. Findings include: R21's significant change Minimum Data Set (MDS) dated 3/9/22, indicated R21 was cognitively intact and able to communicate his thoughts and needs. Additionally, it indicated R21 required extensive assistance with personal cares and was dependent on two staff to assist with mobility, R21's medical diagnoses included hemiparesis/hemiplegia (mild or partial weakness or loss of strength on one side of the body), hypertension (high blood pressure) congestive heart failure (a condition when the heart muscle doesn't pump blood as well as it should, potentially causing shortness of breath, swelling in the legs, ankles and feet), basal cell carcinoma (is a type of skin cancer), diabetes and polyneuropathy (a disease in which peripheral nerves are damaged). R21's care plan, most recently revised on 4/14/21, identified R21 was at risk for skin breakdown related to limited mobility, heart failure, hypertension, polyneuropathy, and hemiplegia. The care plan identified R21 had a chronic wound to left inner ankle. The care plan directed staff to address skin concerns and provide treatment as ordered by provider. The care plan directed staff to monitor skin for	F 684	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents who require compression therapy for non-pressure skin conditions have appropriate orders. -Residents residing in the facility that require compression therapy for non-pressure skin conditions have the potential to be affected if this regulation is not met. -GAW staff have been re-educated to this requirement. - Audits will be completed weekly for four (4) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 6/30/2022.	

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F 684	Continued From page 6	F 684		

breakdown and report symptoms to provider.

On 5/3/22, at 10:59 a.m. R21 stated he was followed by a, "wound doctor" for treatment of the area of basal cell carcinoma on his left lower leg. R21 stated the provider had directed the staff to wrap the leg as it was swollen. R21 stated the wound care provider provided care every other day.

R21's Treatment Administration Record (TAR) printed 5/6/22, directed staff to apply comprilian short stretch wraps (short stretch compression bandage specifically designed for the management of venous leg ulcers, lymphedema, and edema). Staff were directed to apply in the morning and to remove at bedtime. The wraps were to extend from toes to two finger widths below the knee. The start date was identified as 5/3/22. A review of the record indicated the treatment was completed as denoted by the code of a check mark and staff initials for 8:00 p.m. on 5/3/22, however, there was no entry or documentation the morning of 5/4/22. The TAR indicated the treatment was completed at 8:00 p.m. on 5/4/22. On 5/5/22, the TAR indicated the wraps were placed in the morning and removed at bedtime. On 5/6/22, the documentation of 5/6/22 indicated a 9 (not identified on the chart codes) with staff initials.

A review of the 5/2/22 Integrated Wound Care document identified R21's surgical site had failed to heal since Mohs procedure (a surgical removal of the affected tissue with basal cell carcinoma) was completed related to uncontrolled edema. The note identified R21 was on prescribed diuretics (medication to remove excessive swelling and fluid), however, had not been treated

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with compression for promotion of wound healing. The documentation reflected this was reviewed with resident and facility staff.

On 5/6/22, at 10:00 a.m., licensed practical nurse (LPN)-A stated she was aware R21 had edema and indicated R21 was able to communicate his wishes to be laid down so he could elevate his legs. LPN-A reviewed TAR, found the orders for compression, and identified the check mark code indicated the treatment was done. LPN-A stated she had not completed R21's treatment yet today.

On 5/6/22, at 10:31 a.m. R21 was observed lying in bed. R21 Resident stated although the compression wraps were ordered, they have not been implemented. At this time, R21's lower legs and feet had only gripper socks in place.

On 5/6/22, at 11:04 a.m. LPN-A sought out surveyor to inform her R21's treatment had not yet been implemented, as informed by resident and observed by LPN-A. LPN-A stated she was unsure how it was to be documented if the treatment was unable to be completed, although indicated she would have completed a narrative note.

A facility policy, titled Dressings, Dry/Clean, revised September 2013 lacked information regarding use of compression interventions, however, the documentation identified staff were to verify physician orders for the procedure, and inform resident of the procedure. The policy identified staff were to document if the resident refused the procedure, however, lacked staff direction for documentation when treatment was not implemented. A policy was requested for compression therapy but was not received.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		6/30/22

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F 758	Continued From page 9 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure monitoring was implemented following administration of PRN (as needed) psychotropic medication for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/15/22, identified R23 had moderate cognitive impairment, and indicated R23 experienced mild depression. Additionally, the MDS identified no problems with behaviors. R23's medical diagnoses included anxiety, diabetes, and age related cognitive decline. The MDS identified R23 received extensive assistance with dressing, hygiene, toileting, and getting into an upright position. R23's care plan, undated as to date printed, initiated, or reviewed, identified R23 had alteration cognition evidenced by short and long term memory deficits and impaired decision making. The care plan indicated R23 generally was able to be understood and generally understood what was being communicated to her. The care plan identified R23's behavior was	F 758	-The process for satisfying this requirement has been reviewed and revised as needed, to assure there is appropriate monitoring following administration of PRN (as needed) psychotropic medication(s). -Residents who have orders for PRN (as needed) psychotropic medications have the potential to be affected if this regulation/requirement is not met. -GAW staff have been re-educated to the regulation / requirement and/or Monarch Healthcare Policy and Procedure. - Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 6/30/2022.	

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altered secondary to age related cognitive deficit and anxiety. The care plan identified R23 had a history of wandering into other resident's rooms and became upset with redirection. The care plan directed staff to provide redirection. Additionally, staff implemented a stop sign to prevent her from going into other's rooms. The care plan identified R23 had an alteration in psychosocial well being related to adjustment to the facility. Staff were directed to monitor and respond to unmet needs. R23's care plan also identified there was the potential for psychotropic drug (a drug that affects behavior, mood, thoughts, or perception) ADR's (adverse drug reactions-unintended, harmful events attributed to the use of medicines) related to daily use of psychotropic medication. R23 received an anxiolytic (antianxiety) medication. The care plan directed staff to monitor for potential adverse reactions and update the provider regarding any ADR's and also of the efficiency[sic] of medications.

A review of R23's medication was completed and indicated R23 was receiving the following psychotropic medications:

Seroquel (antipsychotic) Tablet 25 mg(milligram) (quetiapine fumarate) 25 mg by mouth in the morning for agitation which was started on 2/26/22.
Buspirone (antianxiety) hcl tablet 10 mg by mouth two times a day for anxiety which was started on 9/29/21.
Melatonin Tablet 3 mg by mouth at bedtime related to other specified anxiety disorder which was started on 3/11/22.

Additionally, R23 had an order for Clonazepam (antianxiety) tablet 0.25 mg by mouth at bedtime

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related to shortness of breath, which was started on 3/31/22. This medication was classified as an antianxiety agent/anticonvulsant-benzodiazepines.

On 5/2/22, at 4:05 p.m. R23 was observed in her room, seated in her recliner. R23 asked what she should be doing. R23 stated she was tired and wished to sleep. At 6:05 p.m. R23 was seated in room in wheelchair and was much more wakeful and able to speak with surveyor.

On 5/5/22, at 2:43 p.m. R23 was observed in her room seated in her room in her wheelchair. Although R23 had her eyes open, and looked toward surveyor when spoken to, she did not respond verbally when asked how she was doing. R23 was observed to have dark brown debris under her lower lip, which appeared as potentially brown gravy or chocolate pudding.

A review of Progress Notes was completed and indicated on 5/4/22, at 8:41 p.m. R23 was experiencing severe agitation. Prior to this time, R23 was identified as being difficult to arouse for supper. At 8:41 p.m. R23 was noted to be very agitated and upset. R23 expressed others were being mean to her. R23 was upset with one caregiver, who left the room. The note went on to indicate R23 remained agitated and was striking out at staff. The note went on to indicate alternate staff members attempted to redirect R23 without success. R23 was noted to be attempting to ambulate without assistive device. The documentation went on to identify attempts to reach out to the power of attorney to have her speak to resident, however, R23 was not willing to do so. The note identified an order for Haldol was received from the nurse practitioner for

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severe agitation. Haldol is an antipsychotic drug-used to treat symptoms of psychosis such as delusions (hearing or seeing things others do not see) hallucinations, paranoia, or confused thoughts. The note identified authorization was received from POA (Power of attorney-person able to make choices for an individual). A review of narrative notes identified the last entry had been completed on 5/4/22, at 11:54 p.m. which identified R23 was given a Haldol injection. The narrative note went on to identify CNA (certified nursing aide) sat with resident to attempt to calm her down. The medical record lacked further documentation to reflect resident response to the medication, pattern of rest over night, ability to wake up to daily activities of living on 5/5/22 and general follow through.

A review was completed of the mood and behavior monitoring completed for R23. On 4/9/22, the notes reflected R23 was calling out and yelling on three occasions. The next episode of behavior was identified on 5/5/22, at which time R23 was noted to be asking repetitive questions on five occasions, however, the behavior remained unchanged when provided reassurance.

On 5/6/22, at 8:40 a.m. a review was completed of both the medication administration record (MAR) and the PRN (as needed) MAR was completed and lacked any documentation of an order for Haldol, or any subsequent administration. Additionally, the Progress Notes lacked documentation of resident assessment, monitoring, or behavior following the last documentation at 5/4/22 at 11:54 p.m. The entries in place on the Progress Notes included the application of Biofreeze Gel on two occasions, as

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well as the documentation of resident refusing TED stockings (support hose) on 5/5/22. .

On 5/6/22, at 9:22 a.m. R23 was observed in her room moving items about in her dresser/armoire. R23 requested assistance for cares, and stated she needed help with, "Woman things". R23 went on to state she would like to have help to comb her hair. R23 was observed to be alert and actively interacting with surveyor. Although questions were repeated, resident responded appropriately with interaction and reassurance.

On 5/6/22, at 9:44 a.m. licensed practical nurse, (LPN)-A stated R23 had experienced a decline in overall well being and identified her behaviors had increased in activity and frequency. LPN-A stated R23 had been restless and agitated on the evening 5/4/22, agitated, confused, walking without walker, wandering into other's room. LPN-A stated R23 had tried to sit on another resident, who was seated in a wheelchair. LPN-A stated an order was obtained for Haldol, and after medication was given, staff sat with R23 until she settled for the evening. A review of the medication administration record (MAR) was completed with LPN-A, and it was found the MAR lacked documentation of the orders for the medication Haldol and it's subsequent administration. A review of the emergency kit log did identify this was removed from the emergency kit for R23. LPN-A stated when orders are received for medication, they are to be transcribed, entered onto the MAR, and reviewed by another staff member as part of the order transcription. Additionally, all medications are to be documented when given. LPN-A stated following administration of a PRN medication, staff documentation would reflect how the resident

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tolerated the medication, and would include monitoring throughout the night. LPN-A stated this documentation would include every two hour checks throughout the night, and through. A review was completed of the electronic medical record (EMR) and LPN-A stated there was no documentation to identify this had been done. Upon further review of the EMR, LPN-A produced a general order of June, 2021, which identified staff would document only when behaviors occurred which was out of the norm for residents, although identified this order was in place upon admission to the facility, and did not reflect the need for behavioral medications, interventions, and follow through on response to administration of psychotropic medications.

On 5/6/22, at approximately 9:30 a.m. a request was made of the administrator for R23's MAR. At approximately 10:00 a.m. , this document was provided. The document had an entry for the order for Haldol as a one time dose for 5/5/22, however, the document indicated the medication was administered on 5/6/22 with registered nurse (RN)-A in place with time identified as 1102. Upon review of previous documents provided, it was noted the facility uses military time, which would have been 2302. Previous MAR reviewed by surveyor lacked this entry when reviewed with LPN-A at 9:44 on 5/6/22. The administrator stated the corporate nurse consultant (CNC) had prepared the document and she (administrator) was unaware of the entry status. A document was then provided at approximately 10:30 a.m. identified as a "Teachable Moment", unsigned and dated 5/6/22, for RN-A, completed by CNC regarding transcription of orders, documentation of medication administration, and resident monitoring following administration of PRN

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F 758	Continued From page 15 medication. On 5/6/22, at 1:57 p.m. the corporate infection preventionist (CIP) stated it was the expectation documentation would be in place for transcription of physician orders, administration of medications, and follow through monitoring of R23's status. CIP stated we see lacking documentation as a concern and, "we are committed to improving the environment." A policy, Medication and Treatment Orders, revised July, 2016, identified the orders of medications and treatments will be consistent with principles of safe and effective order writing. The policy identified only the authorized persons are allowed to take verbal orders from practitioners. Orders received were to be recorded on the Physician's Order Sheet in the resident's chart. Verbal orders were to be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's name, credentials, and date and time of the order. A policy was requested for PRN intramuscular medication administration was requested and was not received.	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		6/30/22

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F 804	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was served at the proper temperature for palatability for 3 of 3 residents (R5, R8, R24) reviewed for meal tray delivery concerns. Findings include: On 5/2/22, at 2:07 p.m. R5 stated she eats in her room and the food is, "horribly cold by the time it gets here." On 5/2/22, at 3:23 p.m. R8 stated she eats in her room and, "the food is so-so and not hot when I get it". On 5/2/22, R24 stated when she orders a food tray, the food, "is good, but it's always cold". On 5/6/22, at 11:30 a.m. dietary aide (DA)-A obtained temperatures for all food items in the steam table prior to dining room service. The food temperatures were as follows: boneless chicken wings 164.3 degrees Fahrenheit (F), tater tots 183 degrees F, ground chicken 157 degrees F, candied corn 145 degrees F, and mashed potatoes 179 degrees F. At 11:46 p.m. DA-A obtained food temperatures for all items prior to meal tray set-up. The food temperatures were as follows: boneless chicken wings 154 degrees F, tater tots 171 degrees F, ground chicken 157 degrees F, candied corn 167 degrees F, and mashed potatoes 184 degrees F. After obtaining the temperatures, DA-A set-up 11 resident meal trays and 1 test tray and placed each in an insulated tray cart.	F 804	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure food delivered via meal trays are served at proper temperatures -All residents who receive meal tray delivery have the potential to be affected if this regulation is not met. -Necessary GAW staff have received education to the requirement/regulation and training utilizing Monarch Healthcare Management policy and procedure. -Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Culinary Services Director or designee is responsible party. -Corrective action will be completed by 6/30/2022.	

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At 12:02 p.m. DA-A left the dining area with the closed food tray cart to begin room tray delivery.

After the last resident room tray was delivered at 12:13 p.m. the test tray temperatures were obtained and tested for palatability by DA-A and surveyor. The boneless chicken wings were 109.3 degrees F and cool to taste, tater tots were 105.2 degrees F and cool to taste, and the candied corn was 125.6 degrees F and slightly warm to taste.

Resident Council Meeting Minutes dated 1/10/22, indicated the dietary manager (DM) would start implementing weekly test trays to audit food temperatures.

On 5/6/22, DM provided Test Tray Assessments for 1/20/22, 2/3/22, 2/17/22, 2/21/22, 2/28/22, 3/30/22, and 4/14/22. Food temperatures at the point of dining were obtained for every item on each test tray, and all items were below the standard food temperature (above 130 degrees F) and were documented as follows:

1/20/22, breakfast egg 90.5 degrees F
1/20/22, lunch hot entrée 93.8 degrees F, starch 83.2 degrees F, and vegetable 96.1 degrees F
1/20/22, supper hot entrée 108.5 degrees F, vegetable 96 degrees F
2/3/22, breakfast hot entrée 119.8 degrees F
2/17/22, breakfast eggs 97 degrees F, hot cereal 115.9 degrees F
2/17/22, lunch pork loin 107.7 degrees F, mashed potatoes 110 degrees F, broccoli 110.6 degrees F
2/17/22, supper hot entrée 124 degrees F, vegetables 88.3 degrees F
2/21/22, breakfast omelet 105 degrees F

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F 804	Continued From page 18 2/21/22, lunch roast beef 110 degrees F, baked potato 111 degrees F, and sweet corn 108 degrees F 2/21/22, supper ravioli 100 degrees F 2/28/22, breakfast hot cereal 116.1 degrees F, omelet 96.6 degrees F 2/28/22, lunch roast beef 116.8 degrees F, broccoli 117 degrees F 2/28/22, supper ravioli 111 degrees F 3/30/22, breakfast eggs 104 degrees F 3/30/22, lunch chicken tenders 117 degrees F, vegetable 96 degrees F 3/30/22, supper hot entree 103.3 degrees F, potato wedges 90.8 degrees F 4/14/22, breakfast eggs 100 degrees F 4/14/22, lunch pork loin 107 degrees F, sweet potatoes 118.6 degrees F, spinach 114 degrees F On 5/6/22, at 4:45 p.m. administrator stated the facility has had several different meetings about food temperatures and quality with just staff, and food council meetings had been initiated again. The administrator further stated that the facility has not timed the room tray set-up and tray delivery service times, nor implemented measures to ensure food is served at a palatable temperature. The facility's Meal Tray Service policy, revised 9/2012, it is the facility's policy to offer meals delivered to residents' rooms in an attractive manner, observing temperatures.	F 804		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		6/3/22

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	245459	A. BUILDING _____ B. WING _____	C 05/06/2022

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F 880	Continued From page 19	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 20 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to analyze monthly surveillance data for trends and patterns to reduce the spread of illness and infections. This had the potential to effect all 38 residents residing in the facility. Findings include: The January 2022, infection spreadsheet identified two urinary tract infections acquired prior to admission, five facility acquired cellulitis infections (a common, potentially serious bacterial skin infection), one prosthetic hip infection acquired prior to admission, and 3 central line infections acquired prior to admission,	F 880	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure GAW has an Infection Prevention program/procedure for analyzing surveillance data to track, reduce, or prevent the spread of illness and /or infections in the facility. -All Residents residing in the facility have the potential to be affected if this regulation is not met. -Necessary GAW staff have received training utilizing Monarch Healthcare policy and procedure on Infection Control and Prevention in order to track, reduce,	

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F 880	Continued From page 21 one which was identified as methicillin-resistant Staphylococcus aureus (MRSA, a bacterium with antibiotic resistance). The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented. The February 2022, infection spreadsheet identified four infections which included one facility acquired cellulitis, two urinary tract infections one facility acquired and one acquired prior to admission, and one on antibiotics as prophylactic (use of antibiotics to prevent a bacterial infection). Although the facility Quality Assurance and Performance Improvement (QAPI) is a data driven and proactive approach to quality improvement) notes identified two residents with MRSA, this was not reflected on the infection spreadsheet. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented. The March 2022, infection spreadsheet identified one resident with thrush with squamous cell cancer of mouth, one prophylactic antibiotic for history of urinary tract infection with a catheter, duplicate data on one person, which was existing from previous month. This did not contain data aside from antibiotics. It does not complete the onset date, infection type, system, or symptoms, merely as a carry over. Six urinary tract infections were identified, three were acquired prior to admission, three were facility acquired. Although there are 7 UTI's, the spreadsheet does not address if they meet the McGeers Criteria/or any criteria. No indication of yes or no on the column designated for this. One cellulitis identified. Although osteomyelitis is indicated in the QAPI	F 880	or prevent the spread of illness and/or infections in the facility. -Audits will be completed five (5) times per week for two (2) weeks; three (3) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or Infection Preventionist designee is responsible party. -Corrective action will be completed by 6/3/2022.	

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F 880	Continued From page 22	F 880		

notes, this not reflected on the March spreadsheet. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

The April 2022, infection spreadsheet identified three urinary tract infections, not identified if they were facility acquired or acquired prior to admission. One diagnosis of pneumonia acquired prior to admission. Six cases of norovirus (a very contagious virus that causes vomiting and diarrhea) was identified. Facility provided documentation of norovirus education provided n staff meeting on 4/13/22. Of note, the presence of Norovirus was identified as occurring after the date of the presentation. The infection spreadsheet failed to identify norovirus residents having been placed on transmission based precautions. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

During interview on 5/4/22, at 2:48 p.m. with corporate infection preventionist and administrator it was stated that in the absence of a director of nursing and facility infection preventionist, the facility nurses followed up with the doctors and documented any necessary precautions, the information was then shared during morning meetings. The facility infections were reviewed during the QAPI (quality assurance and performance improvement) meetings monthly. Although the QAPI minutes were provided, The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

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F 880	Continued From page 23 During interview on 5/6/22, at 1:40 p.m. corporate infection preventionist stated the expectation was to document when transmission based precautions were started and when ended, "if the documentation is missing, it's missing." lack of documentation is lack of big concern. The facility Infection Prevention and Control Policy reviewed 9/21, indicated "The primary mission is to establish and maintain and infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections." The Policy identified important facet of infection prevention was to "implementing appropriate isolation precautions when necessary." Data analysis was identified as "data gathered during surveillance used to oversee infections and spot trends."	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 20, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: Z7KH11

Dear Administrator:

The above facility was surveyed on May 2, 2022 through May 6, 2022 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:

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

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments	2 000		

*****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:
Revised 2567 as a result of an Informal Dispute Resolution.

On 5/2/2022-5/6/2022, a standard licensing survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the

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2 000	Continued From page 1 requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5459073C (MN 00083041) H5459076C (MN 00081549) H5459074C (MN 00078157) H54591140C (MN 00083088) However NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be unsubstantiated: H54591105C (MN00083117) and H5459075C (MN 00082135). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 2 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine bathing/showering assistance for 1 of 5 residents	2 920	corrected	6/30/22

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2 920	Continued From page 3 (R39) reviewed for activities of daily living who required assistance with bathing. Findings include: R39's annual Minimum Data Set (MDS) dated 4/6/22, indicated R39 was cognitively intact. Section G of the MDS indicated R39's bathing had not occurred during the look back period of 7 days. R39's care plan dated 2/12/21, indicated R39 required assistance of one for physical help in part of bathing activity. When interviewed on 5/2/22, at 1:48 p.m. R39 sated, "I would just like to have a bath," and indicated that she had not been getting a bath weekly which is, "aggravating," resident further stated "This is my home, I should be able to have a bath" Review of R39's orders identified order dated 5/31/20, weekly skin inspection by licensed nurse, ensure shower is completed every Sunday, prefers shower around 9:45 a.m. R39's Point of Care (POC) Follow Up Question Report for March 2022, indicated staff should have assisted R39 with a shower on 3/6/22, 3/13/22, 3/20/22 and 3/27/22. However, the bathing was not signed off as being provided on 3/9/22, 3/13/22, or 3/27/22. R39's POC Follow Up Question Report for April 2022, R39 was to have bathing completed on 4/3/22, 4/10/22, 4/17/22 and 4/24/22. However, the bathing was not signed off as being provided on 4/3/22 or 4/10/22. When interviewed on 5/5/22, at 1:25 p.m. nursing assistant (NA)-A stated R39 never refuses a	2 920		

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2 920	Continued From page 4 shower. Staffing could be difficult at times, there was no problem completing resident cares. During interview on 5/5/22, at 1:30 p.m. NA-C voiced R39 never refused bathing, stating she's the one that kept them on top of things. When interviewed on 5/6/22, at 3:39 p.m. clinical manager (CM)-A stated R39 does not refuse her shower, there had just been an in-service regarding showers and cares. CM-A stated it was unacceptable to not get showers done. A policy regarding bathing was requested, however, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living, including assistance with bathing. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was	2 960	corrected	6/30/22

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2 960	Continued From page 5 served at the proper temperature for palatability for 3 of 3 residents (R5, R8, R24) reviewed for meal tray delivery concerns. Findings include: On 5/2/22, at 2:07 p.m. R5 stated she eats in her room and the food is, "horribly cold by the time it gets here." On 5/2/22, at 3:23 p.m. R8 stated she eats in her room and, "the food is so-so and not hot when I get it". On 5/2/22, R24 stated when she orders a food tray, the food, "is good, but it's always cold". On 5/6/22, at 11:30 a.m. dietary aide (DA)-A obtained temperatures for all food items in the steam table prior to dining room service. The food temperatures were as follows: boneless chicken wings 164.3 degrees Fahrenheit (F), tater tots 183 degrees F, ground chicken 157 degrees F, candied corn 145 degrees F, and mashed potatoes 179 degrees F. At 11:46 p.m. DA-A obtained food temperatures for all items prior to meal tray set-up. The food temperatures were as follows: boneless chicken wings 154 degrees F, tater tots 171 degrees F, ground chicken 157 degrees F, candied corn 167 degrees F, and mashed potatoes 184 degrees F. After obtaining the temperatures, DA-A set-up 11 resident meal trays and 1 test tray and placed each in an insulated tray cart. At 12:02 p.m. DA-A left the dining area with the closed food tray cart to begin room tray delivery. After the last resident room tray was delivered at	2 960		

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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) COMPLETE DATE
2 960	Continued From page 6 12:13 p.m. the test tray temperatures were obtained and tested for palatability by DA-A and surveyor. The boneless chicken wings were 109.3 degrees F and cool to taste, tater tots were 105.2 degrees F and cool to taste, and the candied corn was 125.6 degrees F and slightly warm to taste. Resident Council Meeting Minutes dated 1/10/22, indicated the dietary manager (DM) would start implementing weekly test trays to audit food temperatures. On 5/6/22, DM provided Test Tray Assessments for 1/20/22, 2/3/22, 2/17/22, 2/21/22, 2/28/22, 3/30/22, and 4/14/22. Food temperatures at the point of dining were obtained for every item on each test tray, and all items were below the standard food temperature (above 130 degrees F) and were documented as follows: 1/20/22, breakfast egg 90.5 degrees F 1/20/22, lunch hot entrée 93.8 degrees F, starch 83.2 degrees F, and vegetable 96.1 degrees F 1/20/22, supper hot entrée 108.5 degrees F, vegetable 96 degrees F 2/3/22, breakfast hot entrée 119.8 degrees F 2/17/22, breakfast eggs 97 degrees F, hot cereal 115.9 degrees F 2/17/22, lunch pork loin 107.7 degrees F, mashed potatoes 110 degrees F, broccoli 110.6 degrees F 2/17/22, supper hot entrée 124 degrees F, vegetables 88.3 degrees F 2/21/22, breakfast omelet 105 degrees F 2/21/22, lunch roast beef 110 degrees F, baked potato 111 degrees F, and sweet corn 108 degrees F 2/21/22, supper ravioli 100 degrees F 2/28/22, breakfast hot cereal 116.1 degrees F, omelet 96.6 degrees F	2 960		

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2 960	Continued From page 7 2/28/22, lunch roast beef 116.8 degrees F, broccoli 117 degrees F 2/28/22, supper ravioli 111 degrees F 3/30/22, breakfast eggs 104 degrees F 3/30/22, lunch chicken tenders 117 degrees F, vegetable 96 degrees F 3/30/22, supper hot entree 103.3 degrees F, potato wedges 90.8 degrees F 4/14/22, breakfast eggs 100 degrees F 4/14/22, lunch pork loin 107 degrees F, sweet potatoes 118.6 degrees F, spinach 114 degrees F On 5/6/22, at 4:45 p.m. administrator stated the facility has had several different meetings about food temperatures and quality with just staff, and food council meetings had been initiated again. The administrator further stated that the facility has not timed the room tray set-up and tray delivery service times, nor implemented measures to ensure food is served at a palatable temperature. The facility's Meal Tray Service policy, revised 9/2012, it is the facility's policy to offer meals delivered to residents' rooms in an attractive manner, observing temperatures. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review dining services as it relates to timely delivery of resident meals. The director of nursing or designee, could conduct random audits of resident meals, both in the dining room and with room service, and implement interventions to ensure food is served at the apporpriate temperature to maintain palatability. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 960		

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21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to analyze monthly surveillance data for trends and patterns to reduce the spread of illness and infections. This had the potential to effect all 38 residents residing in the facility. Findings include: The January 2022, infection spreadsheet identified two urinary tract infections acquired prior to admission, five facility acquired cellulitis infections (a common, potentially serious bacterial skin infection), one prosthetic hip infection acquired prior to admission, and 3 central line infections acquired prior to admission, one which was identified as methicillin-resistant Staphylococcus aureus (MRSA, a bacterium with antibiotic resistance). The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented. The February 2022, infection spreadsheet identified four infections which included one facility acquired cellulitis, two urinary tract infections one facility acquired and one acquired prior to admission, and one on antibiotics as prophylactic (use of antibiotics to prevent a bacterial infection). Although the facility Quality	21375	corrected	6/30/22

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Assurance and Performance Improvement (QAPI) is a data driven and proactive approach to quality improvement) notes identified two residents with MRSA, this was not reflected on the infection spreadsheet. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

The March 2022, infection spreadsheet identified one resident with thrush with squamous cell cancer of mouth, one prophylactic antibiotic for history of urinary tract infection with a catheter, duplicate data on one person, which was existing from previous month. This did not contain data aside from antibiotics. It does not complete the onset date, infection type, system, or symptoms, merely as a carry over. Six urinary tract infections were identified, three were acquired prior to admission, three were facility acquired. Although there are 7 UTI's, the spreadsheet does not address if they meet the McGeers Criteria/or any criteria. No indication of yes or no on the column designated for this. One cellulitis identified. Although osteomyelitis is indicated in the QAPI notes, this not reflected on the March spreadsheet. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

The April 2022, infection spreadsheet identified three urinary tract infections, not identified if they were facility acquired or acquired prior to admission. One diagnosis of pneumonia acquired prior to admission. Six cases of norovirus (a very contagious virus that causes vomiting and diarrhea) was identified. Facility provided documentation of norovirus education provided n staff meeting on 4/13/22. Of note, the presence of

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Norovirus was identified as occurring after the date of the presentation. The infection spreadsheet failed to identify norovirus residents having been placed on transmission based precautions. The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

During interview on 5/4/22, at 2:48 p.m. with corporate infection preventionist and administrator it was stated that in the absence of a director of nursing and facility infection preventionist, the facility nurses followed up with the doctors and documented any necessary precautions, the information was then shared during morning meetings. The facility infections were reviewed during the QAPI (quality assurance and performance improvement) meetings monthly. Although the QAPI minutes were provided, The facility lacked an analysis of the infections/illness' and if any patterns or trends were noted including any interventions implemented.

During interview on 5/6/22, at 1:40 p.m. corporate infection preventionist stated the expectation was to document when transmission based precautions were started and when ended, "if the documentation is missing, it's missing." lack of documentation is lack of big concern.

The facility Infection Prevention and Control Policy reviewed 9/21, indicated "The primary mission is to establish and maintain and infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections." The Policy identified important facet of infection prevention was to "implementing appropriate

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21375	Continued From page 11 isolation precautions when necessary." Data analysis was identified as "data gathered during surveillance used to oversee infections and spot trends." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure the comprehensive infection control (IC) program contains on-going analysis of collected data to prevent potential spread of illness and to ensure that policies are appropriately implemented. This process could include comparison of data from previous time period, and evaluate the effectiveness of the interventions implemented. The DON could inservice staff regarding proper infection control measures, as well as current education as identified with presenting patterns. The DON or designee could implement audits to ensure ongoing compliance and report those results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.	21535		6/30/22

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21535	Continued From page 12 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure monitoring was implemented following administration of PRN (as needed) psychotropic medication for 1 of 5 residents (R23) reviewed for unnecessary medications. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/15/22, identified R23 had moderate cognitive impairment, and indicated R23 experienced mild depression. Additionally, the MDS identified no problems with behaviors. R23's medical diagnoses included anxiety, diabetes, and age related cognitive decline. The MDS identified R23 received extensive assistance with dressing, hygiene, toileting, and getting into an upright position. R23's care plan, undated as to date printed, initiated, or reviewed, identified R23 had alteration cognition evidenced by short and long	21535	corrected	

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term memory deficits and impaired decision making. The care plan indicated R23 generally was able to be understood and generally understood what was being communicated to her. The care plan identified R23's behavior was altered secondary to age related cognitive deficit and anxiety. The care plan identified R23 had a history of wandering into other resident's rooms and became upset with redirection. The care plan directed staff to provide redirection. Additionally, staff implemented a stop sign to prevent her from going into other's rooms. The care plan identified R23 had an alteration in psychosocial well being related to adjustment to the facility. Staff were directed to monitor and respond to unmet needs. R23's care plan also identified there was the potential for psychotropic drug (a drug that affects behavior, mood, thoughts, or perception) ADR's (adverse drug reactions-unintended, harmful events attributed to the use of medicines) related to daily use of psychotropic medication. R23 received an anxiolytic (antianxiety) medication. The care plan directed staff to monitor for potential adverse reactions and update the provider regarding any ADR's and also of the efficiency[sic] of medications.

A review of R23's medication was completed and indicated R23 was receiving the following psychotropic medications:

Seroquel (antipsychotic) Tablet 25 mg(milligram) (quetiapine fumarate) 25 mg by mouth in the morning for agitation which was started on 2/26/22.
Buspirone (antianxiety) hcl tablet 10 mg by mouth two times a day for anxiety which was started on 9/29/21.
Melatonin Tablet 3 mg by mouth at bedtime related to other specified anxiety disorder which

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21535	Continued From page 14 was started on 3/11/22. Additionally, R23 had an order for Clonazepam (antianxiety) tablet 0.25 mg by mouth at bedtime related to shortness of breath, which was started on 3/31/22. This medication was classified as an antianxiety agent/anticonvulsant-benzodiazepines. On 5/2/22, at 4:05 p.m. R23 was observed in her room, seated in her recliner. R23 asked what she should be doing. R23 stated she was tired and wished to sleep. At 6:05 p.m. R23 was seated in room in wheelchair and was much more wakeful and able to speak with surveyor. On 5/5/22, at 2:43 p.m. R23 was observed in her room seated in her room in her wheelchair. Although R23 had her eyes open, and looked toward surveyor when spoken to, she did not respond verbally when asked how she was doing. R23 was observed to have dark brown debris under her lower lip, which appeared as potentially brown gravy or chocolate pudding. A review of Progress Notes was completed and indicated on 5/4/22, at 8:41 p.m. R23 was experiencing severe agitation. Prior to this time, R23 was identified as being difficult to arouse for supper. At 8:41 p.m. R23 was noted to be very agitated and upset. R23 expressed others were being mean to her. R23 was upset with one caregiver, who left the room. The note went on to indicate R23 remained agitated and was striking out at staff. The note went on to indicate alternate staff members attempted to redirect R23 without success. R23 was noted to be attempting to ambulate without assistive device. The documentation went on to identify attempts to reach out to the power of attorney to have her	21535		

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speak to resident, however, R23 was not willing to do so. The note identified an order for Haldol was received from the nurse practitioner for severe agitation. Haldol is an antipsychotic drug-used to treat symptoms of psychosis such as delusions (hearing or seeing things others do not see) hallucinations, paranoia, or confused thoughts. The note identified authorization was received from POA (Power of attorney-person able to make choices for an individual). A review of narrative notes identified the last entry had been completed on 5/4/22, at 11:54 p.m. which identified R23 was given a Haldol injection. The narrative note went on to identify CNA (certified nursing aide) sat with resident to attempt to calm her down. The medical record lacked further documentation to reflect resident response to the medication, pattern of rest over night, ability to wake up to daily activities of living on 5/5/22 and general follow through.

A review was completed of the mood and behavior monitoring completed for R23. On 4/9/22, the notes reflected R23 was calling out and yelling on three occasions. The next episode of behavior was identified on 5/5/22, at which time R23 was noted to be asking repetitive questions on five occasions, however, the behavior remained unchanged when provided reassurance.

On 5/6/22, at 8:40 a.m. a review was completed of both the medication administration record (MAR) and the PRN (as needed) MAR was completed and lacked any documentation of an order for Haldol, or any subsequent administration. Additionally, the Progress Notes lacked documentation of resident assessment, monitoring, or behavior following the last documentation at 5/4/22 at 11:54 p.m. The entries

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in place on the Progress Notes included the application of Biofreeze Gel on two occasions, as well as the documentation of resident refusing TED stockings (support hose) on 5/5/22. .

On 5/6/22, at 9:22 a.m. R23 was observed in her room moving items about in her dresser/armoire. R23 requested assistance for cares, and stated she needed help with, "Woman things". R23 went on to state she would like to have help to comb her hair. R23 was observed to be alert and actively interacting with surveyor. Although questions were repeated, resident responded appropriately with interaction and reassurance.

On 5/6/22, at 9:44 a.m. licensed practical nurse, (LPN)-A stated R23 had experienced a decline in overall well being and identified her behaviors had increased in activity and frequency. LPN-A stated R23 had been restless and agitated on the evening 5/4/22, agitated, confused, walking without walker, wandering into other's room. LPN-A stated R23 had tried to sit on another resident, who was seated in a wheelchair. LPN-A stated an order was obtained for Haldol, and after medication was given, staff sat with R23 until she settled for the evening. A review of the medication administration record (MAR) was completed with LPN-A, and it was found the MAR lacked documentation of the orders for the medication Haldol and it's subsequent administration. A review of the emergency kit log did identify this was removed from the emergency kit for R23. LPN-A stated when orders are received for medication, they are to be transcribed, entered onto the MAR, and reviewed by another staff member as part of the order transcription. Additionally, all medications are to be documented when given. LPN-A stated following administration of a PRN medication, staff

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documentation would reflect how the resident tolerated the medication, and would include monitoring throughout the night. LPN-A stated this documentation would include every two hour checks throughout the night, and through. A review was completed of the electronic medical record (EMR) and LPN-A stated there was no documentation to identify this had been done. Upon further review of the EMR, LPN-A produced a general order of June, 2021, which identified staff would document only when behaviors occurred which was out of the norm for residents, although identified this order was in place upon admission to the facility, and did not reflect the need for behavioral medications, interventions, and follow through on response to administration of psychotropic medications.

On 5/6/22, at approximately 9:30 a.m. a request was made of the administrator for R23's MAR. At approximately 10:00 a.m. , this document was provided. The document had an entry for the order for Haldol as a one time dose for 5/5/22, however, the document indicated the medication was administered on 5/6/22 with registered nurse (RN)-A in place with time identified as 1102. Upon review of previous documents provided, it was noted the facility uses military time, which would have been 2302. Previous MAR reviewed by surveyor lacked this entry when reviewed with LPN-A at 9:44 on 5/6/22. The administrator stated the corporate nurse consultant (CNC) had prepared the document and she (administrator) was unaware of the entry status. A document was then provided at approximately 10:30 a.m. identified as a "Teachable Moment", unsigned and dated 5/6/22, for RN-A, completed by CNC regarding transcription of orders, documentation of medication administration, and resident monitoring following administration of PRN

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21535	Continued From page 18 medication. On 5/6/22, at 1:57 p.m. the corporate infection preventionist (CIP) stated it was the expectation documentation would be in place for transcription of physician orders, administration of medications, and follow through monitoring of R23's status. CIP stated we see lacking documentation as a concern and, "we are committed to improving the environment." A policy, Medication and Treatment Orders, revised July, 2016, identified the orders of medications and treatments will be consistent with principles of safe and effective order writing. The policy identified only the authorized persons are allowed to take verbal orders from practitioners. Orders received were to be recorded on the Physician's Order Sheet in the resident's chart. Verbal orders were to be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's name, credentials, and date and time of the order. A policy was requested for PRN intramuscular medication administration was requested and was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the system in place, with applicable policies and procedures, to ensure potential side effects of psychotropic medications administered are monitored for, documented, reviewed, and reported. The DON or designee could educate all appropriate staff. The DON or designee could audit to ensure ongoing compliance and report those results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one	21535		

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21535	Continued From page 19 (21) days.	21535		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced	21825		6/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	C 05/06/2022

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) COMPLETE DATE
21825	Continued From page 20 by: Based on interview and document review the facility failed to inform a responsible party in advance, of the risks and benefits and receive consent of proposed care for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13's significant change Minimum Data Set (MDS) dated 2/9/22, indicated severe cognitive impairment and a diagnosis of vascular dementia with behavioral disturbance. Emergency Room Visit Summary dated 4/4/22, indicated an order to start haloperidol (an antipsychotic medication with a black box warning of increased risk of death when given to elderly patients with dementia) 2 mg/mL, take 2.5 ml (5 mg) by mouth twice a day for 7 days. However, an Informed Consent for Required Medications indicating possible risks/side effects was not provided to the responsible party for haloperidol 2 mg/ml. Physician Orders indicated an order dated 4/26/22, for scheduled haloperidol lactate concentrate 2 mg/ml, give 2.5 mg by mouth one time daily. However, an informed consent indicating possible risks/side effects was not provided to the responsible party for haloperidol 2 mg/ml. On 5/6/22, at 4:37 p.m. the administrator acknowledged that an informed consent was not, but should have been, obtained from the responsible party for haloperidol 2 mg/ml. The facility's Psychotropic Medication Use policy, undated, indicated informed consent including	21825	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	C 05/06/2022

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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21825	Continued From page 21 effects and potential side effects will be obtained from resident and/or responsible party for each psychotropic medication. SUGGESTED METHOD OF CORRECTION: Suggested Method of correction: The director of nursing (DON) or designee could review the resident and resident representative patient rights, develop policies/procedures, and educate all staff on the rights of the resident's representative. The facility then could develop an auditing system as part of their quality assurance activities to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

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
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 05/04/2022. At the time of this survey, The Gardens at 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 was a one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. Therefore, at the time of the survey were surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a licensed capacity of 65 beds and had a census of 37 at the 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.