

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 13, 2021

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

RE: CCN: 245459

Cycle Start Date: April 27, 2021

Dear Administrator:

On April 27, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

The Gardens At Winsted LLC May 13, 2021 Page 2

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 27, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

The Gardens At Winsted LLC May 13, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by October 27, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 06/07/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245459	B. WING				C 27/2021
	PROVIDER OR SUPPLIER	LLC			ESS, CITY, STATE, ZIP CODE STREET NORTH IN 55395	1 0-47	2172021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULE S-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 0	00			
	was completed at y complaint investiga Winsted LLC was fo	/21, an abbreviated survey our facility to conduct tion(s). The Gardens at ound not in compliance with Requirements for Long Term					
	The following comp substantiated:	laints were found to be					
	H5459045C (MN66	895); deficiency cited at F578.					
		laints were found to be h no deficiencies issued:					
	H5459043C (MN71 H5459044C (MN67 H5459046C (MN66 H5459047C (MN64 H5459048C (MN62	554) 614) 155)					
		of the investigations, pliance was identified and					
	signature is not req page of the CMS-29 submission of the F verification of comp acceptance. Upon relectronic POC, an may be conducted compliance with the attained in accordar	diance upon the Department's receipt of an acceptable on-site revisit of your facility to validate that substantial e regulations has been nce with your verification.					
F 578 SS=D		scntnue Trmnt;Formlte Adv Dir 6)(8)(g)(12)(i)-(v)	F 5	78			4/28/21
LABORATOR\	 DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
	ically Signed						05/21/2021

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			3) DATE SURVEY COMPLETED	
		245459	B. WING			C / 27/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 551 FOURTH STREET NORTH WINSTED, MN 55395		21/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 578	§483.10(c)(6) The right discontinue treatment to participate in exprormulate an advantage of services as the right provision of meservices deemed minappropriate. §483.10(g)(12) The requirements specificate of services deemed minappropriate. §483.10(g)(12) The requirements specificate of surgical residents concerning medical or surgical residents concerning medical or surgical residents option, for (ii) These requirements of this includes a variety of specific or surgical resident's option, for (iii) This includes a variety of specific or surgical resident's option, for (iii) The solities are perentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission as information or articular that executed an admay give advance of individual's resident with State Law. (v) The facility is no provide this information or she is able to reconstruction.	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to ce directive. Ing in this paragraph should be ght of the resident to receive dical treatment or medical redically unnecessary or In facility must comply with the fied in 42 CFR part 489, Directives). In this paragraph should be ght of the resident to receive dical treatment or medical redically unnecessary or In facility must comply with the fied in 42 CFR part 489, Directives). In this paragraph should be ght of the include provisions to written information to all adult and the information of the implement advance directives are law. In this paragraph should be given to receive the implement advance directives are law. In this paragraph should be given to receive the implement advance directives are law. In this paragraph should be given to receive the field of the implement advance directives are law.	F 5	778			

PRINTED: 06/07/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245459	B. WING			04/5	
NAME OF	PROVIDER OR SUPPLIER	240400	D: Wiite		FREET ADDRESS, CITY, STATE, ZIP CODE	04/2	27/2021
	RDENS AT WINSTED	LLC		55	51 FOURTH STREET NORTH VINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	the information to the appropriate time. This REQUIREMENDY: Based on interview facility failed to ensign Sustaining Treatment adequately community response (EMS), and of 1 resident (R3) cardio-pulmonary retheir wishes. Findings include: R3's quarterly Minimality 10/13/20, identified memory impairment assistance with activation of the composition of the	ne individual directly at the NT is not met as evidenced and document review, the ure Physicians Orders for Life ent (POLST) were clarified, nicated to emergency and implemented as written for reviewed who received esuscitation (CPR) against mum Data Set (MDS), dated R3 had long and short-term and required extensive exities of daily living (ADLs). The profile, printed 4/27/21, along the top of R3's record (EMR) which outlined the top of R3's record (EMR) whic	F 5	578	R3 is no longer a resident at The Gardens at Winsted. Residents POLST's have been revifor accuracy with no changes. Staff education initiated on Monarch Healthcare Management's Cardiopulmonary Resuscitation pol specific to when CPR should be initiand when not to initiate CPR, when notify family/responsible party and dialogue with dispatch and/or EMS regarding residents specific POLST guidelines. Audits will be performed daily 7 day week on accuracy of POLST for ne admission, then weekly x 4 weeks, monthly x 2 months, then PRN. Audits of staff quizzes for 5 staff me weekly x 4 weeks, monthly x 2 monthen PRN. The facility will conduct of drills monthly x 6 months and quart thereafter. The audit results will be reviewed be committee and changed in frequence scope will be adjusted based on the results. Director of Nursing/Designee will be responsible.	icy tiated to s x 1 w embers oths, code erly y QAPI cy and	

"Do Not Attempt Resuscitation." The POLST

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		0.45.450				С
		245459	B. WING			04/27/2021
	PROVIDER OR SUPPLIER RDENS AT WINSTED			STREET ADDRESS, CITY, STATE, 2 551 FOURTH STREET NORTH WINSTED, MN 55395	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 578	continued and direct outlined in the sub not in cardiopulmor included, "LIMIT IN REVERSIBLE CO these as, "Provide treatment of new connor-life threatenin of invasive or uncongenerally be limited room] presumed). With a single check intubate." Further, interventions and the acceptable to unantibiotics and using nose or mouth. The nursing home staff practitioner, and Resident was found laying the acceptable to unantibiotics and using home staff practitioner, and Resident was found laying the acceptable to unantibiotic sand using home staff practitioner, and Resident was found laying the acceptable to unresponsive, responsive, responsive, responsive, responsive acceptable to the unresponsive acceptable to t	age 3 ected to implement order(s) sequent section(s) if R3 was mary arrest. These orders NTERVENTIONS AND TREAT NDITIONS," and explained interventions aimed at or reversible illness / injury or g chronic conditions. Duration omfortable interventions should d. (Transport to ER [emergency " This statement was concluded kmark placed next to, "Do not the POLST outlined additional treatments for R3 which would use; including oral and/or IV ng a tube feeding through the the POLST was signed by a f member, R3's certified nurse (3's family member (FM)-A. et, dated 10/23/20, identified R3 on the floor in her room at 4:20 and her moaning. R3 was ding from her nose, poirations of 10, O2 90%, no ed at that time." The nurse d to the room and directed the a aide (TMA) to call 911. The 11 notified, POLST reviewed. See to begin CPR. They were DNR but they stated to start see began compressions, AED ident, no shocks were given." and assumed R3's care. R3 the hospital via ambulance at the A was updated with a	F 5	578		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245459	B. WING _		04	/27/2021
	THE GARDENS AT WINSTED LLC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 4 dated 10/23/20, identified R3 was found on th floor in her nursing home room after a presumable fall. The note continued, "She has bloody nose and was unresponsive. The staff notified EMS who recommended they start CI Once EMS arrived, patient was found to have pulse, still unresponsive with oxygen saturation in the 60s (percent) on room air." The note outlined the physician discussed R3's status wher FM-B who voiced, " [R3] would not wan aggressive life-sustaining treatments" Treatment options were discussed and the note concluded, "The decision was made to admit patient with comfort measures only." Further, report outlines a physical exam was complete which noted, "Lungs: Diffusely coarse. There mild bruising over the upper sternum, suspect from CPR." R3's subsequent (nursing home) progress not dated 10/29/20, identified R3 had expired whith hospitalized. On 4/26/21, at 1:17 p.m. R3's FM-A was contacted. At 2:06 p.m. a return call was provided to R3 had been found on the floor unresponsive early in the morning on 10/23/21 and 911 was called who directed the nursing home staff member to perform CPR despite heing DNR / DNI which resulted in broken ribs FM-A expressed they were not upset about the care provided to R3, however, questioned "die			STREET ADDRESS, CITY, STATE, ZIP CODE 551 FOURTH STREET NORTH WINSTED, MN 55395		, - , , , , , , , , , , , , , , , , , , ,
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 578	dated 10/23/20, ide floor in her nursing presumable fall. The bloody nose and we notified EMS who is Once EMS arrived pulse, still unrespoin the 60s (percent outlined the physich her FM-B who void aggressive life-sus Treatment options concluded, "The depatient with comfor report outlines a physich noted, "Lung mild bruising over from CPR." R3's subsequent (id dated 10/29/20, ide hospitalized. On 4/26/21, at 1:17 contacted. At 2:06 and FM-A was interevents leading up them with "unanswexplained R3 had burresponsive early and 911 was called home staff member being DNR / DNI we FM-A expressed the care provided to R somebody error in first to seek guidant the hospital where	entified R3 was found on the home room after a he note continued, "She had a as unresponsive. The staff recommended they start CPR., patient was found to have a nsive with oxygen saturations) on room air." The note ian discussed R3's status with ed, " [R3] would not want taining treatments" were discussed and the note ecision was made to admit the treasures only." Further, the hysical exam was completed as: Diffusely coarse. There is the upper sternum, suspect the upper sternum, suspect hursing home) progress note, entified R3 had expired while to R3's death and voiced it left thered questions." FM-A peen found on the floor in the morning on 10/23/20, if who directed the nursing art to perform CPR despite her which resulted in broken ribs. Hey were not upset about the	F 57	8		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CON	(X3) DATE SURVEY COMPLETED	
		245459	B. WING _			C / 27/2021	
	PROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP C 551 FOURTH STREET NORTH WINSTED, MN 55395		121/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 578	days before she particles of the particl	e. p.m. registered nurse (RN)-A nterview. A return call was m. and RN-A verified she was when R3 had been found er room floor. RN-A described thing" when she entered the ble to recall if R3 had a ot. RN-A explained she eted a nursing assistant (NA) to and the NA proceeded to read which affirmed R3 was a DNR the treatments" being checked. The serion of the 'selective they responded, "We don't the decision was made to be what they say" to do. RN-A o 911 "over and over" R3 was ney still directed her to begin	F 57	78			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED C
		245459	B. WING_		04	//27/2021
	PROVIDER OR SUPPLIER RDENS AT WINSTED	LLC		STREET ADDRESS, CITY, STATE, ZIP COD 551 FOURTH STREET NORTH WINSTED, MN 55395	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 578	"very emotional" will such. RN-A stated discussed the ever contacting 911 in R should another sim the POLST and ac RN-A expressed, ir family prior to 911 vince "selective tre were unclear on the family intended with she had learned to and reviewed POL added, "They [man I've just been doing Consultant (RNC) a operations (RDO) vexplained staff mereducation for POLS hire and "ongoing a verified RN-A was a performed CPR on POLST directing not done, at the directivoiced they had invroot-cause analysis discovered the telebeen transferred from the personnel and the did not get passed telephone call. As a the administrator to always repeat infor POLST information	nich may have contributed to the management had since at with her, and they had voiced 3's situation "was fine" but illar event happen, to reference t as it instructed (i.e., DNR). In hindsight, contacting the would have been beneficial atment" was checked and they be exact meaning or wishes the in such. Further, RN-A stated ensure she herself observed ST(s) since R3's event but agement] didn't tell me that.	F 57	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245459	B. WING				C 27/2021
	PROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZII 551 FOURTH STREET NORTH WINSTED, MN 55395	P CODE	0-41	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 578	was reviewed. The DNR/DNI with select copy of R3's progres which verified R3 had labeled, "Action Plastaff on reading and calling 911." In addited 11/30/20, was education had been resident's POLST proceeding of their direction." The the nurse managers POLST and concluded concluded and their direction. The the nurse managers POLST and concluded and their direction on this, proceeding the nurse had at additional four nurs 12/11/20. However, none of the subsequent education and the subsequent education and the subsequent education on the subsequent education four nurs 12/11/20. However, none of the subsequent education on the subsequent education on the subsequent education four nurs 12/11/20. However, none of the subsequent education on the subsequent education on the subsequent education on the subsequent education on the subsequent education of the subseq	/12/20, identified R3's event RCA outlined R3 as a ctive treatment and included a less note (dated 10/23/20) and CPR performed. A section in," directed, "1. Education to direporting POLST when tion, a Nurse Meeting agenda, is provided. This outlined in discussed on referencing a prior to contacting EMS. This is idents do not want to be could be calling the family for education outlined not just is were able to complete a ded, "If you would like blease reach out to me or mager." Further, an attached diended the meeting with an identified the ded and the meeting with an including have a POLST ment' checked, with staff to owledge on how to proceed if the owledge on how to proceed if the on the POLST was present. The evidence provided in the policy of the provided of the prov	F 5	78			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING) ´CON	(X3) DATE SURVEY COMPLETED	
		245459	B. WING			C / 27/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 551 FOURTH STREET NORTH WINSTED, MN 55395		72772021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	event happened and to ensure such edu DON verified if R3 should have been president's wishes a expressed each sit "kind of tricky" depoincluding selective the POLST. The adquestion or investigijust refuse or stop phad a signed POLS measures. Further, both verified no edu system-wide, including trained medication with a CPR event; in completed on when when to ensure fand a limited response wished. On 4/27/21, at 9:55 (MD)-A was intervised chance to review Rexpressed R3 had the floor in her roor (RN-A) to contact Sems where they "gon R3. MD-A acknown to" the nurse reasoning" to reiter and making a clinic really deserving of explained geriatric assess" as they has symptoms which, a	age 8 ad despite 911 directing them acation was completed. The as breathing then no CPR beformed against "the as happened; however, uation can be different and ending on what options, treatment, were identified on dministrator voiced she did not gate why RN-A simply did not performing CPR knowing R3 at in place directing DNR / DNI at the administrator and DON ucation had been done ding with nursing assistants or aides, who may have to assist nor had any education been a to start or withhold CPR or nily is contacted prior to EMS if (i.e., selective treatment) is a.m. R3's primary physician ewed and verified she had a a's's medical record. MD-A been found unresponsive on m which prompted the nurse all who then transferred her to lave the order" to begin CPR bewledged there was confusion uation and voiced it "comes should have "had the clinical ate R3 as a DNR / DNI to EMS cal decision of "was she [R3] CPR at the time." MD-A patients were often "difficult to the times, can be mistaken for en they really were not	F 5	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245459	B. WING		04	C / 27/2021
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 551 FOURTH STREET NORTH WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 578	supportive of sus breathing). As a r nurse acted reason treatment' selected always reverse lifextubate) but count much time had languays seen as not important to "edungravity of R3's site directives are important to selective treatments can then become expressed she be some trauma from age and poor coording in the second could not recall if event when it occur transition of medit however, reiterated opportunity to revent whome staff and entered and record in the staff and entered in the second contraction of second contractions of second contrac	page 9 tainable life (i.e., cheyne stokes result, MD-A voiced she felt the phable given R3 had 'selective ed on her POLST as they could re-sustaining treatments (i.e., ald never provide them if too psed. MD-A added, "Omission is regligence." MD-A stated it was cate all the nurses" on the requation and making sure POLST plemented, including when rent was selected as treatment a gray zone thing." MD-A relieved R3 likely sustained im it [CPR]" but added given her printion she did not feel it was a." Further, MD-A stated she she had been updated on this rurred as the facility was in cal directors at the time; and R3's event served as an riew POLST(s) with the nursing insure any "gray zone" areas are d. MD-A added, "This is why we	F 5	i78		
	dated 11/2019, id response plans we resident based or needs, preference. The policy outline upon admission a considered a valid the physician. The emergency occur provided, according resident's representations.	epulmonary Resuscitation policy, entified individual emergency vere to be developed for each in their individual assessment, es, and advanced directives. End a POLST would be completed and as needed, and was individual order once signed by the policy directed, "When an is, the nurse will guide care and to the resident and/or entative identified preferences obysician's orders and within the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NTIFICATION NUMBER: A. BUILDING COMPLETE		PLETED	
		245459	B. WING _			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,	
THE GAR	RDENS AT WINSTED	LLC		551 FOURTH STREET NORTH WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	plan of care." Howe	ever, the policy lacked any nace on how to act if uncertainty I POLST, or if EMS is giving resident' wishes.	F 57			5/26/21
	S483.75(g) Quality §483.75(g) Quality §483.75(g) Quality §483.75(g)(2) The organization of the correct identification of the c	assessment and assurance. quality assessment and ee must: blement appropriate plans of entified quality deficiencies; NT is not met as evidenced and document review, the ure the quality assessment broughly investigated, acted hally addressed potential with regards to Physician taining Treatment (POLST) correctly during emergency potential to affect all 45 in the facility at the time of the ent (POLST) were clarified, inicated to emergency and implemented as written for reviewed who was found eir room and received esuscitation (CPR) against	F 80	R3 is no longer a resident at The Gardens at Winsted. The facility will and has been ensur that all high-risk concerns are broug QAPI committee to ensure thorough investigation, appropriate action tak and systemically addressing of consisting completed during emergent situations. Administrator educated on QAPI to ensure appropriate discussion, thor investigations and review of system risk concerns or potential of concernative meeting minutes monthly committee meeting minutes monthly months, quarterly x 6 months, and the needed to ensure the facilities QAP committee completes/discusses the investigated, acted upon, and system addressed potential high-risk concerns will be reviewed by	ring ght to h ken, cerns ncy rough nic high rns. r QAPI ly x 6 then as PI orough emically erns. by QAPI	5/26/21
		esuscitation (CPR) against 578 FOR ADDITIONAL		The audit results will be reviewed b committee and changed in frequent scope will be adjusted based on the	cy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 t. BOILD			С
		245459	B. WING		04	/27/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•	
THE CA	RDENS AT WINSTED	11.6		551 FOURTH STREET NORTH		
THE GA	KDENS AT WINSTED	LLC		WINSTED, MN 55395		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 867	A provided Quality Performance Improduction included, "Dependent of the highest interventions, residuand management performance Improducted to help revise or improve of items for a PIP, the consider: high-risk problem-prone are quality of care and staff." Further, the analysis and approducted to help revise or improve of items for a PIP, the consider: high-risk problem-prone are quality of care and staff." Further, the analysis and approducted to help revise or improvement our of address the identificant fishbone dia "To prevent future improvement our of address the identificant periodic measurem implemented considerations (RNC) apperations (RNC) apperations (RNC) apperations (RDO) explained staff metallic measurem in the periodic measurem implemented considerations (RNC) apperations (RDO) explained staff metallic measurem in the periodic measurem implemented considerations (RNC) apperations (RDO) explained staff metallic measurem in the periodic measurem implemented considerations (RDO) explained staff metallic m	Assurance/Assessment and overment Plan, dated 4/8/21, e using an on-going, data approach to advance the quality all residents at the nursing attlined several initiatives the develop policies to address evelop Corrective action or overment activities," to help at levels of safety, clinical and family satisfaction, oractices. The plan directed a overment Plan (PIP) could be take a "systemic approach" to care services. When selecting a plan directed, "Factors we will, high-volume, or as that affect health outcomes, services, and areas that affect plan outlined a systemic plan outlined a systemic plan outlined a systemic plan outlined as analysis, flowcharting, agrams. The plan continued, events and promote sustained organization develops actions to ded root cause and/or so of an issue/event that will be systems level." These on be monitored through ment to ensure changes were	F 8	results. Administrator/Designee will be responsible.	ie	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245459	B. WING		04	//27/2021
				STREET ADDRESS, CITY, STATE, ZIP COD 551 FOURTH STREET NORTH WINSTED, MN 55395		72172021
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 867	hire and "ongoing a verified the nurse ron R3, despite a si measure should be The administrator of the incident using a approach and disciplaced to 911 had lidispatcher to EMS of R3 being a DNR the transferred tele had reiterated to the were educated to a code status and P0 subsequent persor phone in an emerg The RCA, dated 11 was reviewed. The DNR/DNI with selecopy of R3's progres which verified R3 habeled, "Action Plastaff on reading an calling 911." In add dated 11/30/20, was education had been resident's POLST proceed, "If they [resident's POLST proceed to the nurse manager POLST and conclusion on this, proceed to the nurse manager POLST and conclusion on this, proceed to the nurse shad and additional four nurse additional four nurse and additional four nurse were sident to the nurse had an additional four nurse and additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurse and the second eight nurses had an additional four nurses and the second eight nurses had an additional four nurses and the second eight nurses and the second eight n	as needed." The administrator esponded and performed CPR gned POLST directing no such a done, at the direction of EMS. voiced they had investigated a root-cause analysis (RCA) overed the telephone call peen transferred from the 911 personnel and the information adid not get passed along with ephone call. As a result, EMS e administrator to ensure staff always repeat information, like DLST information, to anel they speak with on the ency event. 1/12/20, identified R3's event RCA outlined R3 as a	F 8	67		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245459	B. WING		04	/27/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 551 FOURTH STREET NORTH WINSTED, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	subsequent educa R3's specific scena with 'selective trearensure they had knany unclear directic Further, there was demonstrating the ensuring POLST in telephone call with help ensure contin EMS verbalizing the The administrator items were not educe vent happened and to ensure such educe vent happened and have been resident's wished. The administrator in telephone vent happened and to ensure such educe vent happened and a signed PDNI measures. Further wide, inclutation with a CPR event; completed on when when to ensure far a limited response wished. On 4/27/21, at 9:58 (MD)-A was intervi	tion outlined they had reviewed ario, including have a POLST tment' checked, with staff to nowledge on how to proceed if on on the POLST was present. no evidence provided nurses had been educated on aformation is repeated if the 911 or EMS is transferred to uity of care despite 911 and	F8	67			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION DING			E SURVEY PLETED
						(С
		245459	B. WING			04/2	27/2021
	PROVIDER OR SUPPLIER RDENS AT WINSTED	LLC		STREET ADDRESS, CITY, STATE, ZIP OF 551 FOURTH STREET NORTH WINSTED, MN 55395	OODE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF			N SHOULD	BE	(X5) COMPLETION DATE	
F 867	which prompted the then transferred he order" to begin CPF there was confusion voiced it "comes do "had the clinical rea DNR / DNI to EMS of "was she [R3] reatime." MD-A explain often "difficult to assand subtle sympton mistaken for valid vwere not supportive cheyne stokes breavoiced she felt the R3 had 'selective the POLST as they coulife-sustaining treatic could never provide lapsed. MD-A state all the nurses" on the making sure POLS including when 'sele as treatment can the thing." Further, MD-she had been upda occurred as the factor medical directors at R3's event served a POLST(s) with the any "gray zone" are MD-A added, "This On 4/27/21, at 1:46 was held with the are explained R3's everseveral days afterwishich helped them	e nurse to contact 911 who is to EMS where they "gave the R on R3. MD-A acknowledged in surrounding the situation and own to" the nurse should have asoning" to reiterate R3 as a and making a clinical decision ally deserving of CPR at the ned geriatric patients were sess" as they have frail pulses ms which, at times, can be vital signs when they really e of sustainable life (i.e., athing). As a result, MD-A nurse acted reasonable given reatment' selected on her	F 8	367			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245459	B. WING			C / 27/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 551 FOURTH STREET NORTH WINSTED, MN 55395	•	72772021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 867	administrator voiced be a QA process are interdisciplinary teat verified no additional been implemented adding they felt the the event and any rechanges. The admit an ad-hoc style of to ensure all areas addressed and more "much better process."	d she considered any RCA to and was reviewed with the m (IDT) as such; however, al QA activities (i.e., PIP) had as a result of R3's event RCA was sufficient to capture needed education or process nistrator voiced, in hindsight, QA tool should have been used of education were identified, nitored accordingly as it had sses" for identification of g follow up given R3's event	F 8	67		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 13, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: X8IB11

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 27, 2021 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 <u>only a suggestion</u> 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.

The Gardens At Winsted LLC May 13, 2021 Page 2

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:

> Susie Haben, Unit Supervisor St. Cloud B District Office Licensing and Certification Program **Health Regulation Division** Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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.

· Pro-6

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 06/07/2021 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00352	B. WING			7/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAR	RDENS AT WINSTED I	I I C	RTH STREET), MN 55395	NORTH		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)		DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
		Minnesota Statute, section ction order has been issued				
	pursuant to a surve	y. If, upon reinspection, it is				
	herein are not corre	iency or deficiencies cited ected, a fine for each violation				
		be assessed in accordance ines promulgated by rule of				
	the Minnesota Depa					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of tlack of compliance. re-inspection with a result in the assess	rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	corrected.	ring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted by surve Department of Heal compliance for state complaint investigat (MN71896), H5459	S: 21, an abbreviated survey was yors from the Minnesota lth (MDH) to determine e licensure in conjuction with tion(s): H5459043C 044C (MN67554), H5459047C 046C (MN66614), H5459047C				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/21/21

STATE FORM 6899 If continuation sheet 1 of 16 X8IB11

TITLE

(X6) DATE

Millinesc	ita Department of He	ain				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00352	B. WING		04/2) 7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TUE 0.4	DENG AT MUNICIPED	551 FOUR	TH STREET	NORTH		
THE GAI	RDENS AT WINSTED	WINSTED	, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 1		2 000			
	(MN64155), and H5	5459048C (MN62562).				
	issued. Please indic correction that you and identify the date Minnesota Departmenthe State Licensing federal software. To assigned to Minnesota Nursing Homes. The appears in the far leading the state of the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For any or state of the sta	owing correction orders are cate your electronic plan of have reviewed these order, e when they will be corrected. The ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for the assigned tag number efft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state tement, "This Rule is not met following the surveyors findings Method of Correction and trection.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the	in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf tate.mn.us/divs/fpc/profinfo/inf tate.mn.us/divs/fpc/profinfo/inf tate.mn.us/divs/fpc/profinfo/inf tate.mn.us/divs/fpc/profinfo/info/info/info/info/info/info/inf				

6899

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00252			04/2	
NAME OF		00352	I.		04/2	27/2021
	PROVIDER OR SUPPLIER	551 FOUR	RTH STREET	STATE, ZIP CODE NORTH		
THE GAI	RDENS AT WINSTED	LIC	, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF	2 000			
2 255	A nursing home musesessment and as of the administrator services, the medic designated by the rathree other member representing discipling resident care. The assurance committed respect to which quancessary and development and the services address, at a minimal reporting, infection pharmacy services. This MN Requirements of the services of the serv	est maintain a quality surance committee consisting in the director of nursing all director or other physician nedical director, and at least in the sursing home's staff, lines directly involved in quality assessment and ee must identify issues with ality assurance activities are elop and implement if action to correct identified. The committee must num, incident and accident control, and medications and	2 255	Corrected.		5/26/21

Minnesota Department of Health

STATE FORM KN 6899 X8IB11 If continuation sheet 3 of 16

MILLIESC	ota Department of He	ailli	1		т	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
and Plan	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					c	`
		00352	B. WING		1	, 7/2021
		00332			04/2	112021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		551 FOUR	TH STREET	NORTH		
THE GAI	RDENS AT WINSTED	LLC WINSTED	, MN 55395			
(V4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
2 255	Continued From pa	ne 3	2 255			
2 200	Continued From pa	ge 5	2 200			
	residents residing in	n the facility at the time of the				
	abbreviated survey.					
	Findings include:					
	Based on interview	and document review, the				
		ure Physicians Orders for Life				
	Sustaining Treatme	ent (POLST) were clarified,				
	adequately commu	nicated to emergency				
		nd implemented as written for				
		reviewed who was found				
	unresponsive in their room and received					
		esuscitation (CPR) against				
		578 FOR ADDITIONAL				
	INFORMATION.					
		Assurance/Assessment and				
	•	vement Plan, dated 4/8/21,				
		using an on-going, data				
		pproach to advance the quality				
		Il residents at the nursing				
		lined several initiatives the				
		evelop policies to address				
		evelop Corrective action or				
		vement activities," to help				
		levels of safety, clinical				
		ent and family satisfaction,				
		ractices. The plan directed a vement Plan (PIP) could be				
		ake a "systemic approach" to				
		are services. When selecting				
	consider: high-risk,	plan directed, "Factors we will				
		as that affect health outcomes,				
		services, and areas that affect				
		plan outlined a systemic				
		ach to actions which included				
		se analysis, flowcharting,				
		grams. The plan continued,				
		events and promote sustained				
		ganization develops actions to				
		ed root cause and/or				
		of an issue/event that will				
	Continuating factors	or arr issue/everil trial Will				

Minnesota Department of Health

STATE FORM KN 6899 X8IB11 If continuation sheet 4 of 16

Millinesc	ota Department of He	ain				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						2
		00352	B. WING		1	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY O	STATE, ZIP CODE	<u> </u>	
INAIVIE OF I	FROVIDER OR SUFFLIER					
THE GAI	RDENS AT WINSTED	I I C	RTH STREET	NORTH		
	T		, MN 55395			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 255	Continued From pa	ge 4	2 255			
2 200	-		2 200			
		e systems level." These				
		n be monitored through				
		ent to ensure changes were				
	implemented consis					
		p.m. the administrator,				
		DON), regional nurse				
		nd regional director of				
		vere interviewed. They nbers were assigned				
	education for POLST and Advanced Directives on hire and "ongoing as needed." The administrator					
		esponded and performed CPR				
		aned POLST directing no such				
		done, at the direction of EMS.				
		oiced they had investigated				
		root-cause analysis (RCA)				
		overed the telephone call				
		een transferred from the 911				
	dispatcher to EMS	personnel and the information				
	of R3 being a DNR	did not get passed along with				
		phone call. As a result, EMS				
		e administrator to ensure staff				
		lways repeat information, like				
		DLST information, to				
	' '	nel they speak with on the				
	phone in an emerge					
		/12/20, identified R3's event				
		RCA outlined R3 as a				
		ctive treatment and included a ess note (dated 10/23/20)				
		ad CPR performed. A section				
		n," directed, "1. Education to				
		d reporting POLST when				
		tion, a Nurse Meeting agenda,				
		s provided. This outlined				
		discussed on referencing a				
		prior to contacting EMS. This				
		sidents] do not want to be				
		ould be calling the family for				
		education outlined not just				

Minnesota Department of Health

STATE FORM KN 6899 X8IB11 If continuation sheet 5 of 16

PRINTED: 06/07/2021 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEF		(X1) PROVIDER/SUIDENTIFICATIO		` ′	E CONSTRUCTION		SURVEY PLETED
7.1.2 . 2.1. 0. 00.1.		152. ************************************		A. BUILDING:			
		00352		B. WING			C 27/2021
NAME OF PROVIDER	R OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CARRENC	AT MUNICIFE		551 FOUR	RTH STREET	NORTH		
THE GARDENS	AI WINSTED	LLC	WINSTED	, MN 55395			
	ACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 255 Contin	ued From pa	age 5		2 255			
the nu POLS' educa another Attende eight in addition 12/11// subsect R3's so with 's ensurer any ur Further demonstrately help e EMS with to ensurer to ensure the ensurer that ensurer the ensurer the ensurer the ensurer the ensurer the ensure	rse manager T and conclution on this, per clinical malance Recordurses had about 100. However quent educate they had known a clear direction, there was estrating the mone call with mone	rs were able to conded, "If you would blease reach out nager." Further, and dated 11/30/20 attended the meet sees being educated, none of the provision outlined they ario, including have an entire to have an evidence proving the province of the staff and DON acknown and DON acknown are to the staff and despite 911 direction was compared against and proving the pro	d like to me or an attached , identified ing with an ed later on vided RCA or had reviewed ve a POLST with staff to to proceed if was present. vided educated on eated if the ansferred to te 911 and e. vledged these f since R3's recting them bleted. The en no CPR et "the wever, ferent and options, identified on ed she did not be simply did PR knowing recting DNR / etrator and I been done assistants or have to assist cation been old CPR or	2 255			

Minnesota Department of Health

STATE FORM 8899 X8IB11 If continuation sheet 6 of 16

PRINTED: 06/07/2021 FORM APPROVED

Minnesc	<u>ota Department of He</u>	;alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						
		00352	B. WING		04/2	7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAL	DDENC AT WINCTED	551 FOUR	RTH STREET	NORTH		
THE GAI	RDENS AT WINSTED	WINSTED	, MN 55395			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From pa	ge 6	2 255			
	a limited response wished. On 4/27/21, at 9:55 (MD)-A was intervied been found unrespondent which prompted the then transferred he order" to begin CPF there was confusion voiced it "comes do "had the clinical read DNR / DNI to EMS of "was she [R3] retime." MD-A explair often "difficult to as and subtle symptom mistaken for valid were not supportive cheyne stokes breavoiced she felt the R3 had 'selective tr POLST as they coulife-sustaining treat could never provide lapsed. MD-A state all the nurses" on the making sure POLS including when 'seleas treatment can the thing." Further, MD she had been updated occurred as the fact medical directors a R3's event served a POLST(s) with the any "gray zone" are MD-A added, "This On 4/27/21, at 1:46	(i.e., selective treatment) is is a.m. R3's primary physician awed and expressed R3 had consive on the floor in her room a nurse to contact 911 who is to EMS where they "gave the R on R3. MD-A acknowledged in surrounding the situation and own to" the nurse should have asoning" to reiterate R3 as a and making a clinical decision ally deserving of CPR at the ned geriatric patients were sess" as they have frail pulses ms which, at times, can be vital signs when they really a of sustainable life (i.e., athing). As a result, MD-A nurse acted reasonable given reatment' selected on her				

Minnesota Department of Health

explained R3's event had been reviewed for

STATE FORM 6899 If continuation sheet 7 of 16 X8IB11

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SLIB//EV
	OF CORRECTION	IDENTIFICATION NUMBER:				LETED
			A. BUILDING.			
			B. WING			
		00352	D. WINO		04/2	7/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAE	RDENS AT WINSTED	551 FOUR	TH STREET	NORTH		
THE GAL	NDENS AT WINSTED	WINSTED	, MN 55395			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
170		,	170	DEFICIENCY)		
2 255	Continued From pa	go 7	2 255			
2 200	·		2 233			
		ard at their "morning meeting"				
		determine a root cause				
		ed on R3's event. The				
		d she considered any RCA to nd was reviewed with the				
		m (IDT) as such; however,				
		al QA activities (i.e., PIP) had				
		as a result of R3's event				
	adding they felt the RCA was sufficient to capture					
	the event and any needed education or process					
	changes. The administrator voiced, in hindsight,					
	-	QA tool should have been used				
		of education were identified,				
		nitored accordingly as it had sses" for identification of				
		g follow up given R3's event				
	was a 'high-risk' ev					
		HOD OF CORRECTION: The				
	administrator, or de	signee, could review				
		ies and procedures to ensure				
	all lapsed high-risk					
		e addressed through the				
		ehensive QA processes to				
		onitoring and resolution(s) are				
	compliance.	d then audit to ensure ongoing				
	compliance.					
	TIME PERIOD FOR	R CORRECTION: Twenty-one				
	(21) days.	,				
21840	MN St. Statute 144	.651 Subd. 12 Patients &	21840			4/28/21
	Residents of HC Fa	ac.Bill of Rights				
21840	MN St. Statute 144. Residents of HC Fassidents shall have based on the inform 9. Residents who ror dietary restriction		21840			4/28/21

Minnesota Department of Health

STATE FORM 8899 X8IB11 If continuation sheet 8 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:	·		
	00352	B. WING		04/2	; 7/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT WINSTED	HC	RTH STREET , MN 55395			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
medical record. In a incapable of unders has not been adjud legal requirements treatment, the cond be fully documented the resident's medical tresident's medical tresident's medical tresident's medical tresident's medical tresident's medical tresident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pulmonary response (EMS), and 1 cardio-pulmonary response (EMS), and 1 of 1 resident (R3) cardio-pul	cumentation in the individual cases where a resident is standing the circumstances but icated incompetent, or when limit the right to refuse litions and circumstances shall d by the attending physician in cal record. The ent is not met as evidenced and document review, the ure Physicians Orders for Life ent (POLST) were clarified, nicated to emergency and implemented as written for reviewed who received esuscitation (CPR) against the ent (POLST) was a standard to extensive exities of daily living (ADLs). The ent of the ent of the ent (POLST) which outlined, along the top of R3's record (EMR) which outlined, along the top of R3's record (EMR) which outlined, along the top of R3's record (EMR) which outlined, along the ent of th	21840	Corrected.		

Minnesota Department of Health

STATE FORM 8899 X8IB11 If continuation sheet 9 of 16

Minnesota Department of Health						
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00352	B. WING		04/2	; 7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GA	RDENS AT WINSTED	LIC	TH STREET , MN 55395	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21840	reading, "An autom should not be used "Do Not Attempt Recontinued and direct outlined in the substant in cardiopulmor included, "LIMIT IN REVERSIBLE CON these as, "Provide it treatment of new or non-life threatening of invasive or uncorgenerally be limited room] presumed)." with a single check intubate." Further, tinterventions and tribe acceptable to us antibiotics and usin nose or mouth. The nursing home staff practitioner, and R3 R3's progress note, was found laying or a.m. after staff hear recorded, " bleed unresponsive, respother vitals obtained working was called trained medication note continued, "91 911 instructed nursitold resident was D CPR anyway. Nurse was applied to reside EMS then arrived a was transferred to the substant of the substant o	atic external defibrillator (AED) for a patient who has chosen esuscitation." The POLST eted to implement order(s) equent section(s) if R3 was early arrest. These orders TERVENTIONS AND TREAT IDITIONS," and explained exterventions aimed at reversible illness / injury or chronic conditions. Duration enfortable interventions should. (Transport to ER [emergency This statement was concluded mark placed next to, "Do not the POLST outlined additional eatments for R3 which would be; including oral and/or IV g a tube feeding through the expolst was signed by a member, R3's certified nurse by family member (FM)-A. dated 10/23/20, identified R3 in the floor in her room at 4:20 rd her moaning. R3 was	21840			

R3's corresponding ED History and Physical,

STATE FORM 6899 If continuation sheet 10 of 16 X8IB11

141111111000	ota Department of He	ain				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					c	·
		00352	B. WING			7/2021
			<u>I</u>		04/2	112021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAL	RDENS AT WINSTED	551 FOUR	TH STREET	NORTH		
THE GAI	RDENS AT WINSTED	WINSTED	, MN 55395			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
				DEL TOLETO !)		
21840	Continued From pa	ge 10	21840			
		ntified R3 was found on the				
	floor in her nursing					
		e note continued, "She had a				
		as unresponsive. The staff ecommended they start CPR.				
		patient was found to have a				
		nsive with oxygen saturations				
		on room air." The note				
		an discussed R3's status with				
		ed, " [R3] would not want				
		aining treatments"				
		were discussed and the note				
	•	cision was made to admit the				
		t measures only." Further, the				
		ysical exam was completed				
		s: Diffusely coarse. There is				
	mild bruising over the	ne upper sternum, suspect				
	from CPR."					
	R3's subsequent (n	ursing home) progress note,				
	dated 10/29/20, ide	ntified R3 had expired while				
	hospitalized.					
		p.m. R3's FM-A was				
		o.m. a return call was provided				
		viewed who recalled the				
		o R3's death and voiced it left				
		ered questions." FM-A				
	· ·	een found on the floor				
		in the morning on 10/23/20,				
		who directed the nursing				
		to perform CPR despite her hich resulted in broken ribs.				
		ey were not upset about the				
		B, however, questioned "did				
		calling 911" and not the family				
		ce. R3 was then transferred to				
		she was found to have "septic				
		nained hospitalized for several				
	days before she pa					
		p.m. registered nurse (RN)-A				
		nterview. A return call was				

Minnesota Department of Health

PRINTED: 06/07/2021 FORM APPROVED

Wilnnesc	<u>ita Department of He</u>	ealth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00352	B. WING		1	
		00352			04/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		551 FOUR	RTH STREET	NORTH		
THE GAI	RDENS AT WINSTED	HC	, MN 55395			
	0		-			
(X4) ID PREFIX	-	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
		ŕ		DEFICIENCY)		
0.10.10	0 " 1-		0.1.0.1.0			
21840	Continued From pa	ge 11	21840			
	provided at 3·19 p r	n. and RN-A verified she was				
		when R3 had been found				
		er room floor. RN-A described				
		hing" when she entered the				
		ole to recall if R3 had a				
		ot. RN-A explained she				
		ted a nursing assistant (NA) to				
		nd the NA proceeded to read				
		which affirmed R3 was a DNR				
		e treatments" being checked.				
		estioned the NA(s) present in				
		eaning of the 'selective				
		they responded, "We don't				
		the decision was made to				
		ee what they say" to do. RN-A				
		o 911 "over and over" R3 was				
		ney still directed her to begin				
	CPR. RN-A verified					
		continued them until EMS				
		er the scene. RN-A stated she				
		tiple people had been present				
		f someone else had assumed				
		rough as she never personally				
		ne NA(s) were talking to them				
		loud "what they we're saying"				
		she did not contact R3's				
		g 911, as her care plan				
		noment her concern was with				
		vever, R3's family member(s)				
		the event. RN-A stated she				
		CPR despite knowing R3 was				
		se 911 had directed her to do				
		nt 911 had precedence over				
		RN-A described the entire				
		naotic" and the NA(s) were				
		nich may have contributed to				
		the management had since				.
		t with her, and they had voiced				
		3's situation "was fine" but				
	should another sim	ilar event happen, to reference				

Minnesota Department of Health

PRINTED: 06/07/2021 FORM APPROVED

Minnesota Department of Health							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED	
		00352	B. WING		04/2	; 7/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE CAL	RDENS AT WINSTED	551 FOUR	TH STREET	NORTH			
THE GAI	KDENS AT WINSTED	WINSTED	, MN 55395				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21840	Continued From pa	ge 12	21840				
	the POLST and act RN-A expressed, in family prior to 911 v since "selective trea were unclear on the family intended with she had learned to and reviewed POLS added, "They [mansel've just been doing On 4/26/21, at 1:45 director of nursing (consultant (RNC) a operations (RDO) v explained staff mereducation for POLS hire and "ongoing a verified RN-A was to performed CPR on POLST directing not done, at the direction voiced they had invoiced th	as it instructed (i.e., DNR). I hindsight, contacting the would have been beneficial atment" was checked and they exact meaning or wishes the in such. Further, RN-A stated ensure she herself observed ST(s) since R3's event but agement] didn't tell me that.					

Minnesota Department of Health

staff on reading and reporting POLST when

Minnesota Department of Health							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00352	B. WING	C NG		7/2021	
NAME OF I	PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY (STATE, ZIP CODE	-		
NAIVIE Oi I	TRUVIDER ON SUFFLICIN		RTH STREET	•			
THE GAI	RDENS AT WINSTED	LLC WINSTED	, MN 55395			_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
21840	Continued From pa	ge 13	21840				
	calling 911." In addidated 11/30/20, was education had beer resident's POLST p directed, "If they [re hospitalized, we shot their direction." The the nurse managers POLST and concluded ducation on this, p another clinical mar Attendance Record eight nurses had attadditional four nurse 12/11/20. However, none of the subsequent education in the selective treatment in the selection in the	ition, a Nurse Meeting agenda, is provided. This outlined in discussed on referencing a prior to contacting EMS. This esidents do not want to be could be calling the family for eleducation outlined not just is were able to complete a ded, "If you would like oblease reach out to me or mager." Further, an attached ded the meeting with an eside being educated later on the provided RCA or ion outlined they had reviewed in it. In a contact the meeting with an eside ded to meet a pollot of the provided RCA or ion outlined they had reviewed in it. In a contact the meeting with an eside on the POLST was present. In our evidence provided for on the POLST was present. In our evidence provided in the pollot of the staff to outly of care despite 911 and is should be done. In and DON acknowledged these cated to the staff since R3's ind despite 911 directing them cation was completed. The was breathing then no CPR oberformed against "the as happened; however, uation can be different and ending on what options, treatment, were identified on					
	question or investig	Iministrator voiced she did not pate why RN-A simply did not performing CPR knowing R3					

PRINTED: 06/07/2021 FORM APPROVED

Minnesota Department of Health

winnesc	ita Department of He	aith				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
711012711	or contraction	BERTH 10/11/01/11/01/BERT	A. BUILDING:			
						;
		00352	B. WING		04/2	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
			TH STREET			
THE GAI	RDENS AT WINSTED	I I C	, MN 55395			
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
21840	Continued From pa	ge 14	21840			
	had a signed POLS	T in place directing DNR / DNI				
		the administrator and DON				
	both verified no edu	ıcation had been done				
	system-wide, includ	ling with nursing assistants or				
	trained medication	aides, who may have to assist				
	with a CPR event; r	nor had any education been				
	completed on wher	to start or withhold CPR or				
		nily is contacted prior to EMS if				
	a limited response	(i.e., selective treatment) is				
	wished.					
		a.m. R3's primary physician				
		ewed and verified she had a				
		3's medical record. MD-A				
		been found unresponsive on				
		n which prompted the nurse				
		11 who then transferred her to				
		ave the order" to begin CPR				
		wledged there was confusion				
		uation and voiced it "comes should have "had the clinical				
		ate R3 as a DNR / DNI to EMS				
		al decision of "was she [R3]				
		CPR at the time." MD-A				
	, ,	patients were often "difficult to				
		ve frail pulses and subtle				
	,	t times, can be mistaken for				
		en they really were not				
		nable life (i.e., cheyne stokes				
		sult, MD-A voiced she felt the				
		able given R3 had 'selective				
		on her POLST as they could				
		sustaining treatments (i.e.,				
		never provide them if too				
		sed. MD-A added, "Omission is				
		ligence." MD-A stated it was				
		te all the nurses" on the				
		ition and making sure POLST				
		mented, including when				
	'selective treatment	' was selected as treatment				

Minnesota Department of Health

can then become "a gray zone thing." MD-A

Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						`
		00352	B. WING		04/27/2021	
		00002			07/2	172021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CA	RDENS AT WINSTED	S51 FOUF	RTH STREET	NORTH		
IIIL GAI	VDENS AT WINSTED	WINSTED	, MN 55395			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DAIL
				,		
21840	Continued From pa	ge 15	21840			
	evnressed she helic	eved R3 likely sustained				
		it [CPR]" but added given her				
		tion she did not feel it was				
		" Further, MD-A stated she				
		ne had been updated on this				
		red as the facility was in				
		Il directors at the time;				
		R3's event served as an				
		w POLST(s) with the nursing				
		ure any "gray zone" areas are				
		MD-A added, "This is why we				
	educate people."	,,				
		ulmonary Resuscitation policy,				
		ntified individual emergency				
		re to be developed for each				
		heir individual assessment,				
	needs, preferences	, and advanced directives.				
	The policy outlined	a POLST would be completed				
	upon admission and	d as needed, and was				
	considered a valid r	medical order once signed by				
	the physician. The	policy directed, "When an				
	emergency occurs,	the nurse will guide care				
		to the resident and/or				
		tative identified preferences				
		ysician's orders and within the				
		ever, the policy lacked any				
	J	nce on how to act if uncertainty				
		POLST, or if EMS is giving				
	instruction against r					
		HOD OF CORRECTION: The				
		DON), or designee, could				
		nt records to ensure all				
		ent and reflective of patient'				
		could then educate nurses to				
		POLST implementation; then				
	audit to ensure ong					
		R CORRECTION: Twenty-one				
	(21) days.					

6899

Minnesota Department of Health STATE FORM