DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 24, 2025

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

RE: CCN: 245459
Cycle Start Date: August 15, 2025

Dear Administrator:

On August 15, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

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September 24, 2025

Administrator
THE GARDENS AT WINSTED LLC

551 FOURTH STREET NORTH
WINSTED, MN 55395

Re: Reinspection Results
Event ID: 1D3F68-H2

Dear Administrator:

On September 12, 2025 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 August 15, 2025. 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 27, 2025

Administrator
THE GARDENS AT WINSTED LLC

551 FOURTH STREET NORTH
WINSTED, MN 55395

RE: CCN:245459
Cycle Start Date: August 15, 2025

Dear Administrator:

On August 15, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 November 15, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 15, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 8/14/25 through 8/15/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54592260C (2588238) with deficiencies issued at F550, F656, F690, F838. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		09/10/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of	F0550	R4 and R5's incontinence care preference reviewed including toileting and care plan has been updated. Resident Rights Policy and Call Light Policy reviewed without changes. All residents have the potential to be affected by this deficient practice. Staff to be educated on answering call lights and providing toileting and incontinence care per preference. DON or designee to conduct audits of residents' call light wait times related to toileting and incontinence care preferences weekly times 4 weeks. Audit results to be brought to QAPI for further review and recommendation.	09/10/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

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F0550 SS = D	Continued from page 1 condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to maintain residents' dignity for 2 of 3 residents (R4, R5) reviewed for dignity when it took 20 minutes for staff to answer call lights causing R4 and R5 to become incontinent. Findings included: R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact. R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. It also indicated R4 was on diuretic and BPH medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours. R4's annual Minimum Data Set (MDS) dated 7/9/25 indicated he had diagnoses of heart failure, benign	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

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F0550 SS = D	Continued from page 2 prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status. R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated R4 stated he only had incontinent episodes if staff cannot answer his call light. R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate. The device activity report indicated R4 had his call light on for 20 minutes, starting at 1:40 p.m., on 8/14/25. On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes, leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination.	F0550		

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F0550 SS = D	Continued from page 3 R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated 6/20/25, indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. The device activity report indicated R5 had his call light on for 20 minutes, starting at 1:40 p.m., on 8/14/25. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, "I don't like sitting in wet pants." R5 stated, "This happens often", and that it occurs more often late in the evening and in the middle of the night. On 8/15/25, at 10:10 a.m., the director of nursing (DON) stated she expected call lights to be answered as soon as possible, but within 15 minutes. She stated toileting schedules should be implemented for R4 and R5 to promote continence.	F0550		

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F0550 SS = D	Continued from page 4 On 8/15/25, at 11:50 a.m., the administrator stated the NA's should be answering call lights within 15 minutes. A facility document, Activities of Daily Living (ADLs) Maintain Abilities Policy, dated 3/31/23, directed It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: hygiene, mobility, elimination, dining, and communication. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F0550		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan	F0656	R4 and R5's care plans have been reviewed and updated to reflect changes to their Elimination care plan focus and interventions. Like residents who have been identified to be at risk for incontinence have been reviewed and updated to reflect Elimination care plan focus and interventions. The Care Planning Policy has been reviewed with no changes.	09/10/2025

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F0656 SS = D	Continued from page 5 must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to maintain continence for 2 of 3 residents (R4, R5) reviewed for care plans. Findings include: R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact.	F0656	Continued from page 5 All residents have the potential to be affected by this deficient practice. The DON or designee will provide re-education to all appropriate staff on comprehensive care plans and Elimination interventions to reduce risk of incontinence. The DON or designee will complete audits on comprehensive care plans for residents with or at risk for incontinence to ensure proper Elimination care plan focus and interventions are in place. Audits will be conducted weekly times 4 weeks. Audit results will be reviewed by QAPI Committee for further recommendation.	

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F0656 SS = D	Continued from page 6	F0656		

R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. R4 was on diuretic and benign prostate hyperplasia (BPH) medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours.

R4's annual Minimum Data Set (MDS) dated 7/9/25 indicated he had diagnoses of heart failure, benign prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status.

R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated he stated he "only had incontinent episodes if staff cannot answer his call light."

R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate.

On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes, leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call

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F0656 SS = D	Continued from page 7 wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination. R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated 6/20/25, indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, "I don't like sitting in wet pants." R5 stated, "This happens often", and that it occurs more often late in the evening and in the middle of the night. R5 stated he was not on a toileting schedule.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

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F0656 SS = D	Continued from page 8 On 8/14/25, at 4:43 p.m., NA-A stated residents who cannot use their call lights are on toileting schedules every two hours She stated all other residents use their call light when they need to use the restroom and call lights are answered in the order they are pressed. She stated R4 and R5 were assisted to the bathroom as they requested it and were not on a schedule. On 8/15/25, at 9:48 a.m., NA-C stated R4 and R5 were supposed to be on a toileting schedule on the odd hours, but it was not followed. She stated it was implemented by the previous director of nursing (DON). On 8/15/25, at 10:10 a.m., the DON stated toileting schedules were intended to prevent incontinence episodes, by assisting the resident to the restroom on a regular basis and promote continence. She stated R4 was on a toileting schedule every two hours while awake. She stated the bladder assessment, dated 7/9/25 was not accurate, as it indicated R4 was continent. She also stated it was incomplete as it did not include pertinent diagnosis and medications related to urinary urgency and frequency. The DON stated R5 was not on a toileting schedule. The DON stated based on R5's bladder assessment, dated 12/27/24, she would expect the facility to have implemented a toileting schedule to offer him assistance to the restroom every 2 –3 hours, with a follow up to determine effectiveness. A facility document, Care Planning, dated 11/2024, directed in accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of their care plan. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F0656		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI	F0690	R4 and R5 received appropriate continence care that	09/10/2025

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F0690 SS = D	Continued from page 9 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents incontinent of bladder and bowel received services to maintain continence when 2 of 3 residents (R4, R5) reviewed for continence care did not receive timely care, resulting in bladder incontinence. Findings include: R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. It also indicated R4 was on	F0690	Continued from page 9 adhered to professional standards. R4 and R5's care plans were reviewed to ensure they included information on their continence status and interventions regarding the daily cares and toileting. Orders to monitor R4 and R5's toileting were entered. Facility's Activities of Daily Living (ADL) Policy was reviewed with no changes. All residents have the potential to be affected by this deficient practice. Appropriate staff educated on Activities of Daily Living (ADL) Policy, ensuring a resident is given the appropriate elimination services to maintain or improve his or her ability to carry out their activities of daily living. DON or designee to conduct audits on toileting and incontinence care weekly times 4 weeks. Audit results will be brought to QAPI for further review and recommendation.	

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F0690 SS = D	Continued from page 10 diuretic and BPH medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours. R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact. R4's annual Minimum Data Set (MDS) dated 7/9/25 indicated he had diagnoses of heart failure, benign prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status. R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated he stated he "only had incontinent episodes if staff cannot answer his call light." The assessment lacked pertinent diagnoses that may affect urinary function, identification of medications related to urinary urgency and frequency, voiding patterns. The assessments lacked interventions to manage R4's incontinence. R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate. On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes,	F0690		

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F0690 SS = D	Continued from page 11 leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination. R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. The assessment indicated it was not appropriate for a bladder retraining program. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated 6/20/25, indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, "I don't like sitting in wet pants." R5 stated, "This happens often",	F0690		

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F0690 SS = D	Continued from page 12 and that it occurs more often late in the evening and in the middle of the night. R5 stated he was not on a toileting schedule. On 8/14/25, at 4:43 p.m., NA-A stated residents who cannot use their call lights are on toileting schedules every two hours She stated all other residents use their call light when they need to use the restroom and call lights are answered in the order they are pressed. She stated R4 and R5 were assisted to the bathroom as they requested it and were not on a schedule. On 8/15/25, at 9:48 a.m., NA-C stated R4 and R5 were supposed to be on a toileting schedule on the odd hours, but it was not followed. She stated it was implemented by the previous director of nursing (DON). On 8/15/25, at 10:10 a.m., the DON stated toileting schedules were intended to prevent incontinence episodes, by assisting the resident to the restroom on a regular basis and promote continence. She stated R4 was on a toileting schedule every two hours while awake. She stated the bladder assessment, dated 7/9/25 was not accurate, as it indicated R4 was continent. She also stated it was incomplete as it did not include pertinent diagnosis and medications related to urinary urgency and frequency. The DON stated R5 was not on a toileting schedule. The DON stated based on R5's bladder assessment, dated 12/27/24, she would expect the facility to have implemented a toileting schedule to offer him assistance to the restroom every 2 –3 hours, with a follow up to determine effectiveness. A facility document, Care Planning, dated 11/2024, directed in accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of their care plan. The care plan shall be used in developing the resident's daily care routines and will	F0690		

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F0690 SS = D	Continued from page 13 be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. A facility document, Activities of Daily Living (ADLs) Maintain Abilities Policy, dated 3/31/23, directed It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: hygiene, mobility, elimination, dining, and communication. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F0690		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually.	F0838	Facility assessment has been updated to reflect QSO-24-13-NH regulation requirements. Facility Administrator educated IDT and staff to Facility Assessment regulation specific to annual review/revisions and QSO update. All residents have the potential to be affected by this deficient practice.	09/10/2025

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F0838 SS = F	Continued from page 14 The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any	F0838	Continued from page 14 Administrator/Designee will audit annually for facility review and revisions as needed along with accuracy. QAPI will review audit results and recommend continued audit schedule.	

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F0838 SS = F	Continued from page 15 competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.	F0838		

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F0838 SS = F	Continued from page 16 §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the facility assessment included the required components of involvement from direct care staff, considering staffing needs of each unit in the facility, and a plan to recruit and retain staff. This had the opportunity to affect all 33 residents. Findings include: Review of the facility assessment, dated 7/22/24, failed to include input and active involvement from direct care staff, including but not limited to registered nurses (RN), licensed practical nurses (LPN), and nursing assistants (NA). The document indicated the following people were involved in completing the assessment: administrator, director of nursing (DON), Governing Body representative, the medical director, the pharmacist, and residents/resident representatives/family members through letters, family council and resident council. The facility assessment failed to consider staffing needs for each unit in the facility and failed to consider staffing needs for each shift. The document indicated acuity needs of residents was reviewed and evaluated regularly and determined by resident assessments, care plans, and census. The staffing plan section of the document indicated staffing needs were determined by reviewing the resident population, case mix index (CMI) and census daily. Admissions and discharges assist in determining staffing needs for each day. The facility assessment lacked a plan and maximized recruitment and retention of direct care staff. It also lacked a contingency planning for events that did not require activation of facility's emergency	F0838		

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F0838 SS = F	Continued from page 17 plan, but had the potential to affect resident care, such as availability of direct care nurse staffing or other resources for resident care. The facility daily schedules from 7/15/25 through 8/14/25 indicated the facility staffed nurses and trained medication aides (TMA) for the north and south units. The facility staffed NAs for rooms 200-224, rooms 207-225 and 226-228, 229-244, and a float aide. (Actual room layout is not in numerical sequence.) Facility call light records reviewed for 4 residents from 7/15/25 through 8/14/25 identified excessive call light wait times, with the longest response time of 120 minutes. The review identified the following: • 115 call light wait times that exceeded 20 minutes • 28 call light wait times that exceeded 30 minutes • 50 call light wait times that exceeded 40 minutes • 3 call light wait times that exceeded 50 minutes • 4 call light wait times that exceeded 60 minutes • 2 call light wait times that exceeded 70 minutes • 2 call light wait times that exceeded 80 minutes • 1 call light wait times that exceeded 90 minutes • 1 call light wait time was exceeded 120 minutes On 8/14/25, at 8:10 a.m., family member (FM)-A stated family felt uncomfortable leaving R1 at the facility without their presence due to the facility's slow response time to the call light. FM-A stated they often waited for 40 minutes for the staff to answer the call lights. On 8/14/25, at 1:11 p.m., FM-B stated it was common to wait 45 minutes for R1's call light to be answered. On 8/14/25, at 2:06 p.m., R3 stated she has had to wait for over two hours at times for her call light to be answered, resulting in her sitting in feces, due to the facility cutting staff.	F0838		

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F0838 SS = F	Continued from page 18 On 8/14/25, at 2:30 p.m., R4 stated call wait times were addressed with the facility management through resident council meetings and their response was they had the right number of staff they were required to have. He stated, “There just aren’t enough people.” He also stated he always experienced long call light wait times. R4 stated he pressed his call light at 1:40 p.m., on 8/14/25, to use the commode. He stated he had become incontinent while waiting for staff assistance, which took 20 minutes. On 8/14/25, at 2:40 p.m. R5 stated he put his call light on around 1:30 p.m., on 8/14/25. He stated he had not been incontinent when he first pressed his light, but due to waiting for over 30 minutes, he urinated in his brief. R5 stated it happened often, as the facility was short-staffed, and the wait was worse overnight. On 8/14/25, at 2:55 p.m., R6 stated call wait times were very long. She stated at the last resident council meeting another resident stated he had waited over 2 ½ hours for his call light to be answered. On 8/14/25, at 4:43 p.m., NA-A stated the facility was “cutting staff”, due to empty beds in the facility. She stated, “One person has to go home at 9:00 p.m.” She stated the staff has attempted to address their staffing concerns with management, but felt management did not care. On 8/14/25, at 4:48 p.m., NA-B stated, “I feel like a lot of call lights are on for a long time, it’s been busy, and residents are waiting.” She also stated one NA has to leave the shift early, at 9:00 p.m. NA-AD stated some of the residents had complained about the response time to the call lights. NA-AD stated several residents required the assistance of two staff for transfers. On 8/14/25, at 4:53 p.m., RN-A stated she did not feel the facility had enough staff. She said the residents had to wait for their call lights to be answered, causing them to be incontinent by the time the staff responded. RN-A stated residents had complained about the length of time they had to wait. She stated it was hard when one of the NA’s was required to leave at 9:00 p.m., due to low census. RN-A stated she shared these concerns with management.	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0838 SS = F	Continued from page 19 On 8/15/25, at 8:30 a.m., the staffing coordinator (SC) stated the staffing level was determined by census and nursing hours per patient day (PPD). She stated the facility was trying to cut hours to meet labor and census. She stated she felt it was unsafe to cut any additional hours as they were already “getting quite low on floor staff”. She stated the staff reported they felt they needed more help to her. The SC stated she was cutting hours by having the evening shift come in late and having someone leave the evening shift early. On 8/15/25, at 9:52 a.m., the therapeutic recreation director stated she attended every resident council meeting. She stated call light response times were addressed in almost every meeting and she shared the concerns addressed in the meeting with the appropriate department leaders. On 8/15/25, at 10:10 a.m., the DON stated she felt the facility had enough staffing and had not been told of any concerns by the residents. She stated the call light response times were evaluated if there was a complaint concerning them. The DON stated the call lights should be answered as soon as possible, but within 15 minutes. The DON stated a 45-minute call light response time was not acceptable. On 8/15/25, at 11:50 a.m., the administrator stated the facility assessment was to be completed annually. She stated some residents take two people to be transferred requiring longer time with staff, resulting in residents complaining about the wait times. She stated she reviewed the call light logs if there were complaints. She stated she had not observed any extended call light response times over the last 30 days. The administrator stated the call lights should be answered within 15 minutes. She stated she evaluated the call light response times by running average response times. The facility lacked a policy for the facility assessment.	F0838		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 27, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1D3F68-H1

Dear Administrator:

The above facility was surveyed on August 15, 2025 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/15/2025**

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

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/14/25 through 8/15/25, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders and identify the date when they will be completed. he following complaints were reviewed. H54592260C (2588238) with a licensing order issued at 4658.0405	20000		09/10/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/15/2025**

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20000	Continued from page 1 subp 3. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 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. 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.	20000		
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to maintain continence for 2 of 3 residents (R4, R5) reviewed for care plans.	20565	Corrected.	09/10/2025

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20565	Continued from page 2 Findings include: R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact. R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. R4 was on diuretic and benign prostate hyperplasia (BPH) medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours. R4's annual Minimum Data Set (MDS) dated 7/9/25 indicated he had diagnoses of heart failure, benign prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status. R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated he stated he "only had incontinent episodes if staff cannot answer his call light." R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate. On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the	20565		

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20565	Continued from page 3 staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes, leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination. R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated 6/20/25, indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, "I don't like	20565		

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20565	Continued from page 4 sitting in wet pants." R5 stated, "This happens often", and that it occurs more often late in the evening and in the middle of the night. R5 stated he was not on a toileting schedule. On 8/14/25, at 4:43 p.m., NA-A stated residents who cannot use their call lights are on toileting schedules every two hours She stated all other residents use their call light when they need to use the restroom and call lights are answered in the order they are pressed. She stated R4 and R5 were assisted to the bathroom as they requested it and were not on a schedule. On 8/15/25, at 9:48 a.m., NA-C stated R4 and R5 were supposed to be on a toileting schedule on the odd hours, but it was not followed. She stated it was implemented by the previous director of nursing (DON). On 8/15/25, at 10:10 a.m., the DON stated toileting schedules were intended to prevent incontinence episodes, by assisting the resident to the restroom on a regular basis and promote continence. She stated R4 was on a toileting schedule every two hours while awake. She stated the bladder assessment, dated 7/9/25 was not accurate, as it indicated R4 was continent. She also stated it was incomplete as it did not include pertinent diagnosis and medications related to urinary urgency and frequency. The DON stated R5 was not on a toileting schedule. The DON stated based on R5's bladder assessment, dated 12/27/24, she would expect the facility to have implemented a toileting schedule to offer him assistance to the restroom every 2 –3 hours, with a follow up to determine effectiveness. A facility document, Care Planning, dated 11/2024, directed in accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of their care plan. The care plan shall be used in developing the resident's daily care routines and will	20565		

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20565	Continued from page 5 be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	20565		