Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 30, 2024

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

RE: CCN: 245459
Cycle Start Date: May 14, 2024

Dear Administrator:

On May 14, 2024, a survey was completed at your facility by the Minnesota Department 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 August 14, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 14, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	C 05/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/13/24 and 5/14/24, 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 complaint was reviewed H54593677C (MN00103177) with deficiencies cited at F580 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		6/12/24

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

Electronically Signed | 06/08/2024

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

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F 580	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 580		

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F 580	Continued From page 2 Based on interview and document review the facility failed to notify the resident's representative following resident change of condition for 1 of 1 resident (R1) who had a decline in condition resulting in hospitalization. Findings include: R1's significant change Minimum Data Set (MDS) dated 3/19/24, indicated R1 had severe cognitive impairment. R1's diagnoses included diabetes, morbid obesity, anemia, edema, heart failure, altered mental status, and end stage renal disease. R1 was dependent on staff for dressing, toileting, personal hygiene, transferring, and bed mobility. The MDS also identified R1 had two stage 2 pressure ulcers (presenting as a shallow open ulcer); three stage 3 pressure ulcers (full thickness tissue loss which may include undermining or tunneling) and one unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar). R1's physician orders included: - Tylenol 1000 mg by mouth three times daily for pain; Tramadol 50 mg by mouth every six hours as needed for severe pain (start date 4/3/24). -Wound culture to coccyx ulcer for wound infection; turn resident every two hours; keep all pressure off his coccyx; up to chair only for meals; complete blood count (CBC) for wound infection; Cephalexin 500mg QID for 7 days for wound infection (start date 4/15/24). -Discontinue cephalexin (antibiotic); start Augmentin (antibiotic) 875mg/125mg one (1) tab twice daily for 10 days for wound infection (start date 4/19/24). R1's medical record lacked documentation of	F 580	-The process for satisfying this requirement has been reviewed and revised as needed to ensure that the facility notifies the resident□s representative following a change in their condition. -R1 has since discharged from the facility. -Failure to meet this regulatory requirement could affect all residents who receive wound care at the facility. -A complete house audit was completed to ensure that resident□s representative has been notified of provider driven order changes to wound treatments. - All necessary GAW nursing staff received education regarding facilities notification of changes policy and procedure. -Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Compliance will be achieved on or before 6/12/2024.	

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F 580	Continued From page 3 notification of physician order changes to R1's responsible party on 4/3/24, 4/15/24, and 4/19/24. During interview on 5/13/24 at 2:20 p.m., family member (FM)-A stated she was the responsible party and primary contact for R1. Indicated R1 was hospitalized on 5/2/24 because of an infected ulcer on his tailbone. Further indicated she was unaware that the wound had deteriorated to the extent that it had, and the facility did not notify her of any changes in R1's wounds. During a follow up interview on 5/14/24 at 1:33 p.m., FM-A indicated the facility had not notified her of any of the new orders for antibiotics or pain medications and was unaware until this phone interview. During interview on 5/14/24 at 10:40 a.m., licensed practical nurse (LPN)-A stated R1 had chronic medical issues and did not call the family or responsible party on all of the physician order changes. Stated she was aware of R1's orders for antibiotics but did not call the family. LPN-A further stated it would be "unrealistic" to call the families about wound care orders. During interview on 5/14/24 at 1:51 p.m., registered nurse (RN)-A indicated the policy directed to call with all order changes but was not sure if the policy addressed change of resident condition. Further stated, they (nurses) are supposed to call the resident's responsible person or family member with any order changes but admitted that she "should be better at that." During interview on 5/14/24 at 2:26 p.m., RN-B indicated nurses should be calling families for a	F 580		

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F 580	Continued From page 4 resident's change in condition, fall, become more confused. Further stated, "it is the doctor's job to talk to the responsible party about medication changes. I am not aware that we have to call." During interview on 5/14/24 at 2:33 p.m., RN-C indicated they (nurses) call the responsible party if there is a fall but do not call the responsible party for medication changes. During interview on 5/14/24 at 12:06 p.m., the director of nursing (DON) indicated her expectation was nursing staff contact families for a new or worsening wound, new medications, and medication changes. The facility's Notification of Changes Policy dated 3/2024, indicated it is the policy of the facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment, and preferences to address the changes.	F 580		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		6/18/24

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F 686	Continued From page 5 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to effectively monitor and communicate wound status for early recognition of changes on 1 of 2 residents (R1) reviewed for worsening pressure ulcers. Findings include: R1's significant change in status Minimum Data Set (MDS) dated 3/19/24, indicated R1 had severe cognitive impairment. R1's diagnoses included diabetes, morbid obesity, anemia, edema, heart failure, altered mental status, and end stage renal disease. R1 was dependent on staff for dressing, toileting, personal hygiene, transferring, and bed mobility. The MDS also identified R1 had two stage 2 pressure ulcers (presenting as a shallow open ulcer); three stage 3 pressure ulcers (full thickness tissue loss which may include undermining or tunneling) and one unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar). R1's care plan initiated on 8/16/23, indicated R1 had skin alterations to coccyx, rear right thigh, left 2nd toe, and left heel. Directed nursing staff to document on skin condition, monitor for skin breakdown for signs/symptoms of infection, and to keep medical doctor (MD) or physician's assistant (PA) informed of changes.	F 686	-The process for satisfying this requirement has been reviewed and revised as needed to ensure that the facility establishes and maintains a monitoring process and communication of wound status changes. -R1 has since discharged from the facility. -Failure to meet this regulatory requirement could affect all residents who receive wound care at the facility. -A complete house audit was completed on those residents with wounds to ensure that signs and symptoms of infection monitoring and worsening condition has been initiated. - All necessary GAW nursing staff have received education regarding Wound Care Treatment policy and procedure. All necessary GAW nursing staff have received education to review resident skin & wound forms to compare for any changes in the wound. -Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party	

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F 686	Continued From page 6 R1's wound care note dated 4/8/24, indicated R1 had a stage 3 pressure ulcer on the left heel, stage 3 pressure ulcer on coccyx, stage 3 pressure ulcer left ischial tuberosity (sit bones), stage 3 on right rear thigh, and a new unstageable perianal pressure ulcer due to a medical device. R1's Treatment Administration Record (TAR) identified daily and as needed wound treatments for the rear right thigh pressure ulcer, left 2nd toe, and left heel. The TAR identified twice daily and as needed wound treatments for the perianal pressure ulcer. R1's wound care noted dated 4/29/24, indicated R1 was being treated for the following wounds: 1) unstageable pressure ulcer on the left heel measured 2.9 centimeters (cm) in length x 1.7 cm wide. 2) Venous ulcer 2nd toe dorsal left measured 0.8 cm in length x 0.4 cm wide. 3) unstageable pressure ulcer perianal measured 4.7 cm in length x 3.4 cm wide 4) unstageable pressure ulcer rear right thigh measured 1.4 cm in length x 0.6 cm wide. R1's Progress Notes dated 5/2/24 at 10:57 p.m., indicated R1 was lethargic, non responsive and taken to the emergency room by ambulance. R1's Progress Noted dated 5/3/24 at 8:23 p.m., indicated R1 was admitted to the hospital due to sepsis (infection in the blood) due to infection of the perianal wound. During an interview on 5/14/24 at 10:21 a.m., the nurse manager stated she manages the wounds along with an outside wound care agency.	F 686	-Compliance will be achieved on or before 6/18/2024.	

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F 686	Continued From page 7 Indicated nurse's do weekly skin checks and if any alteration in skin status is noted, she was notified for follow-up. Further indicated it was then referred to the wound care agency and came weekly to assess the wound, gave wound orders, and reviewed interventions. Facility nursing staff were expected to carry out the wound orders as written. Further stated that although the nurse's visualize the wounds during dressing changes, the facility does not have a good process for documenting the monitoring of the wounds. Stated, "it is an area we need to work on". During an interview on 5/14/24 at 10:40 a.m., licensed practical nurse (LPN)-A indicated the nurse's do twice daily wound treatments to R1's wounds and visualize them at that time. If the wound got worse or it showed signs of infection, they would call the doctor and document it. Verified R1 did not have any wound progress notes in the medical record from 4/23/24 to the date of R1's hospitalization for wound infection on 5/2/24. LPN-A indicated it could not be ascertained if/when the wounds changed because there was not documentation to compare. During an interview on 5/14/24 at 1:50 p.m., RN-A indicated she performed routine wound treatments but did not document the condition of the wound in the medical record unless it looked different from her last observation. Further indicated she does not work every day and would not know what the previous nurse observed if it was not documented. RN-A stated she would not know if it changed from one day to the next unless it was in the medical record.	F 686		

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F 686	Continued From page 8 During an interview on 5/14/24 at 12:05 p.m., the director of nursing (DON) indicated nurses observe resident wounds when doing wound treatments but did not expect them to document the condition of the wound unless it changes. Wound care comes in weekly to assess the wounds and adjust any orders as needed. Verified R1's wound status was not documented in the medical record except for the wound care provider. Confirmed that the nurse would not know the condition of the wound on the previous shifts without documentation. The facility policy titled, Wound Care Treatment Procedure dated 2/2024 instructed for every wound dressing change to evaluate the wound and note if there is any presence of possible complications such as: increasing are of skin damage, increased redness or swelling around the wound, pain, an increase in drainage from the wound and the characteristics of the drainage (odor, color, consistency). If there are any changes to the resident's wound appearance, pain, ability to tolerate the dressing change, or resident refusal; notify the provider immediately to collaborate on a new plan of care/treatment.	F 686		

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May 30, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 1HVN11

Dear Administrator:

The above facility was surveyed on May 13, 2024 through May 14, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	05/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/13/24 and 5/14/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54593677C (MN00103177) with a licensing order issued at 0265 and 0900. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		6/12/24

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the resident's representative following resident change of condition for 1 of 1 resident (R1) who had a decline in condition resulting in hospitalization. Findings include: R1's significant change Minimum Data Set (MDS) dated 3/19/24, indicated R1 had severe cognitive impairment. R1's diagnoses included diabetes, morbid obesity, anemia, edema, heart failure, altered mental status, and end stage renal disease. R1 was dependent on staff for dressing, toileting, personal hygiene, transferring, and bed mobility. The MDS also identified R1 had two stage 2 pressure ulcers (presenting as a shallow open ulcer); three stage 3 pressure ulcers (full thickness tissue loss which may include undermining or tunneling) and one unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar). R1's physician orders included: - Tylenol 1000 mg by mouth three times daily for pain; Tramadol 50 mg by mouth every six hours as needed for severe pain (start date 4/3/24). -Wound culture to coccyx ulcer for wound infection; turn resident every two hours; keep all pressure off his coccyx; up to chair only for meals; complete blood count (CBC) for wound infection; Cephalexin 500mg QID for 7 days for	2 265	Corrected	

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2 265	Continued From page 4 wound infection (start date 4/15/24). -Discontinue cephalexin (antibiotic); start Augmentin (antibiotic) 875mg/125mg one (1) tab twice daily for 10 days for wound infection (start date 4/19/24). R1's medical record lacked documentation of notification of physician order changes to R1's responsible party on 4/3/24, 4/15/24, and 4/19/24. During interview on 5/13/24 at 2:20 p.m., family member (FM)-A stated she was the responsible party and primary contact for R1. Indicated R1 was hospitalized on 5/2/24 because of an infected ulcer on his tailbone. Further indicated she was unaware that the wound had deteriorated to the extent that it had, and the facility did not notify her of any changes in R1's wounds. During a follow up interview on 5/14/24 at 1:33 p.m., FM-A indicated the facility had not notified her of any of the new orders for antibiotics or pain medications and was unaware until this phone interview. During interview on 5/14/24 at 10:40 a.m., licensed practical nurse (LPN)-A stated R1 had chronic medical issues and did not call the family or responsible party on all of the physician order changes. Stated she was aware of R1's orders for antibiotics but did not call the family. LPN-A further stated it would be "unrealistic" to call the families about wound care orders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in	2 265		

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2 265	Continued From page 5 treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Day	2 265		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to effectively monitor and communicate wound status for early recognition of changes on 1 of 2 residents (R1) reviewed for worsening pressure ulcers. Findings include: R1's significant change in status Minimum Data	2 900	Corrected	6/12/24

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2 900	Continued From page 6 Set (MDS) dated 3/19/24, indicated R1 had severe cognitive impairment. R1's diagnoses included diabetes, morbid obesity, anemia, edema, heart failure, altered mental status, and end stage renal disease. R1 was dependent on staff for dressing, toileting, personal hygiene, transferring, and bed mobility. The MDS also identified R1 had two stage 2 pressure ulcers (presenting as a shallow open ulcer); three stage 3 pressure ulcers (full thickness tissue loss which may include undermining or tunneling) and one unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar). R1's care plan initiated on 8/16/23, indicated R1 had skin alterations to coccyx, rear right thigh, left 2nd toe, and left heel. Directed nursing staff to document on skin condition, monitor for skin breakdown for signs/symptoms of infection, and to keep medical doctor (MD) or physician's assistant (PA) informed of changes. R1's wound care note dated 4/8/24, indicated R1 had a stage 3 pressure ulcer on the left heel, stage 3 pressure ulcer on coccyx, stage 3 pressure ulcer left ischial tuberosity (sit bones), stage 3 on right rear thigh, and a new unstageable perianal pressure ulcer due to a medical device. R1's Treatment Administration Record (TAR) identified daily and as needed wound treatments for the rear right thigh pressure ulcer, left 2nd toe, and left heel. The TAR identified twice daily and as needed wound treatments for the perianal pressure ulcer. R1's wound care noted dated 4/29/24, indicated R1 was being treated for the following wounds:	2 900		

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2 900	Continued From page 7 1) unstageable pressure ulcer on the left heel measured 2.9 centimeters (cm) in length x 1.7 cm wide. 2) Venous ulcer 2nd toe dorsal left measured 0.8 cm in length x 0.4 cm wide. 3) unstageable pressure ulcer perianal measured 4.7 cm in length x 3.4 cm wide 4) unstageable pressure ulcer rear right thigh measured 1.4 cm in length x 0.6 cm wide. R1's Progress Notes dated 5/2/24 at 10:57 p.m., indicated R1 was lethargic, non responsive and taken to the emergency room by ambulance. R1's Progress Noted dated 5/3/24 at 8:23 p.m., indicated R1 was admitted to the hospital due to sepsis (infection in the blood) due to infection of the perianal wound. During an interview on 5/14/24 at 10:21 a.m., the nurse manager stated she manages the wounds along with an outside wound care agency. Indicated nurse's do weekly skin checks and if any alteration in skin status is noted, she was notified for follow-up. Further indicated it was then referred to the wound care agency and came weekly to assess the wound, gave wound orders, and reviewed interventions. Facility nursing staff were expected to carry out the wound orders as written. Further stated that although the nurse's visualize the wounds during dressing changes, the facility does not have a good process for documenting the monitoring of the wounds. Stated, "it is an area we need to work on". During an interview on 5/14/24 at 10:40 a.m., licensed practical nurse (LPN)-A indicated the nurse's do twice daily wound treatments to R1's wounds and visualize them at that time. If the	2 900		

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2 900	Continued From page 8 wound got worse or it showed signs of infection, they would call the doctor and document it. Verified R1 did not have any wound progress notes in the medical record from 4/23/24 to the date of R1's hospitalization for wound infection on 5/2/24. LPN-A indicated it could not be ascertained if/when the wounds changed because there was not documentation to compare. During an interview on 5/14/24 at 1:50 p.m., RN-A indicated she performed routine wound treatments but did not document the condition of the wound in the medical record unless it looked different from her last observation. Further indicated she does not work every day and would not know what the previous nurse observed if it was not documented. RN-A stated she would not know if it changed from one day to the next unless it was in the medical record. During an interview on 5/14/24 at 12:05 p.m., the director of nursing (DON) indicated nurses observe resident wounds when doing wound treatments but did not expect them to document the condition of the wound unless it changes. Wound care comes in weekly to assess the wounds and adjust any orders as needed. Verified R1's wound status was not documented in the medical record except for the wound care provider. Confirmed that the nurse would not know the condition of the wound on the previous shifts without documentation. F686 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure	2 900		

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2 900	Continued From page 9 ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		