DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 2, 2025

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

RE: CCN: 245459
Cycle Start Date: February 24, 2025

Dear Administrator:

On March 28, 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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Electronically delivered

April 2, 2025

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

Re: Reinspection Results
Event ID: 4XJ412

Dear Administrator:

On March 28, 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 February 24, 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
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2025

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

RE: CCN: 245459
Cycle Start Date: February 24, 2025

Dear Administrator:

On February 24, 2025, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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 May 24, 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 August 24, 2025 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	C 02/24/2025

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 2/20/25 and 2/24/25, 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: H54597223C (MN00110543) with a deficiency cited at F880 and F921. H54597386C (MN00110619). 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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		3/14/25

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

Electronically Signed | 03/14/2025

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 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 880	Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 2 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was utilized for 3 of 4 residents (R1, R2, R4) reviewed for infection control concerns. Furthermore, the facility failed to ensure enhanced barrier precaution (EBP) [measure intended to prevent the spread of multi drug-resistant organisms] was implemented for 2 of 4 residents (R1, R4) reviewed for foley catheter cares. Findings include: R1 R1's Admission Record dated 6/21/2023, indicated R1's diagnoses included urinary tract infection, sepsis, and retention of urine. R1's quarterly Minimum Data Set dated 12/20/24, indicated R1 had intact cognition and required moderate assistance of two persons with an easy stand (EZ) for transfers.	F 880	The process for satisfying this requirement has been reviewed and revised as necessary to ensure enhanced barrier precautions (EBPs) are implemented for residents with foley catheters and appropriate personal protective equipment (PPE) is utilized for infection prevention. All residents residing in the facility have the potential to be affected if this requirement is not met. Necessary staff have all received education utilizing Monarch Healthcare Management policy and procedure to ensure both EBPs and PPE are appropriately in use. Audits will be completed to ensure compliance with this requirement. Audits will be completed three (3) times per week for two (2) weeks; weekly for two (2)	

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F 880	Continued From page 3 R1's care plan dated 12/20/24 indicated R1 had foley catheter, moderate assist for toilet hygiene with staff interventions included follow EBP direction while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities. On 2/10/25 at 00:50 a.m. a progress note indicated no output from catheter, R1 bypassing urine, foley catheter was removed and new 16 French with 10cc in balloon was placed. R1 tolerated the procedure and denied pain or discomfort. On 2/20/25 at 1:15 p.m. a progress note indicated a urologist had been notified about R1 recent hospitalization and her urinary tract infection (UTI) status. On 2/24/25 at 9:09 a.m., during an observation, R1 had her foley catheter under her wheelchair (w/c) but no EBP signage noted on her door. On 2/24/25 at 3:06 p.m. RN-A stated R1's room should have a signage since she had a foley catheter. RN-A stated they should have worn gowns and gloves when transferring R1 from the chair to the bed. R2 R2's Admission Record dated 4/6/2024, indicated R2's diagnoses included bladder disorder and neuromuscular dysfunction of bladder. R2's care plan dated 4/6/2024 indicated R2 had indwelling foley catheter with staff interventions	F 880	weeks, monthly thereafter for one (1) month. Any deficient practice will be corrected at the time of occurrence, and results will be reviewed at QAPI. The Director of Nursing or designee is responsible for compliance. Compliance date: 03/14/2025	

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F 880	Continued From page 4	F 880		

included follow EBP direction while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities.

On 2/20/25 at 12:31p.m. nursing assistant (NA)-A and a licensed practical nurse (LPN)-A have been observed transferring R2 who had an indwelling foley catheter with Enhance Barriers Precaution (EBP) signage on the door without donning gown and gloves. NA-A removed the foley catheter from the chair to the bed without gloves on. NA-A then picked up from the floor the soiled linen left in the resident room and put it in the bag with no gloves on. A soiled brief was in the garbage can opened in the room and the bathroom.

On 2/20/25 at 12:43 p.m. NA-A stated she did not know how long the soiled linen was on the floor in the resident's room nor the soiled briefs. NA-A confirmed R2 was on EBP due to the Foley catheter and staff were expected to wear gowns and gloves during high contact care including transfers, brief changes, and dressing changes. NA-A stated she should have put gown and gloves on when providing cares to a resident with a foley catheter with EBP on the door.

On 2/24/25 at 10:54 a.m. NA-D brought R2 to his room, NA-D did not wear gown or gloves. NA-D applied a transfer belt on R2, removed his foley catheter from the chair to the bed and called NA-E to help transferred R2 to bed which was high contact care activity. Both failed to wear gowns during the transfer with EZ.

On 2/24/25 at 11:03 a.m. NA-D stated a gown and gloves were expected to be worn during

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F 880	Continued From page 5 transfers for residents on EBP. NA-D acknowledged she should have worn a gown and gloves while providing high contact care activity to R2. R4 R4's Admission Record dated 1/23/25, indicated R4's diagnoses included acute kidney failure, neoplasm of kidney, retention of urine, and infection inflammatory reaction due to indwelling urethral catheter. R4's care plan dated 1/23/25 indicated R4 had indwelling foley catheter with staff interventions included follow EBP direction while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities. On 2/20/25 at 4:08 p.m. No signage of EBP on the R4's door noted. R4 had a foley catheter. NA-B and NA-C transferred R4 with no gowns and no gloves on. NA-B, after touching the foley catheter with no gloves on, went out to the clean utility to get a blanket for the resident without washing hands, and then took the resident to the dining room, touching the dining table where the resident was sitting. On 2/20/25 at 4:28 p.m. NA-B indicated any resident with foley catheter should be on EBP and the staff was made aware by the signage on the door. NA-B verified R4 had a foley catheter and no precaution signage was on R4's door. On 2/20/25 at 4:30 p.m. NA-C stated she was not aware R4 was on EBP precautions and confirmed PPE was not worn during the care and transfers	F 880		

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F 880	Continued From page 6 of R4. On 2/20/25 at 4:32 p.m. RN-B stated when a resident has a foley catheter, staff should put EBP signage on the door. RN-B did not know why R4 did not have EBP signage on his door. On 2/24/25 at 3:37 p.m. the director of nursing (DON), known also as the infection preventionist, stated R1 had recently been inserted a foley catheter back and should be on EBP precautions. The DON stated she was not aware about R1 change in condition. The DON stated she should have worn gloves and gown while caring for R1. The DON stated EBP signage should have been posted on R1's door. She expected all staff to be knowledgeable EBP and wear proper PPE when caring for residents on EBP precaution. The DON stated, she started a full house reeducation about infection control. The facility Enhanced Barrier Precaution policy dated 4/1/2024 indicated enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activities included dressing, transferring, changing linens, and device care or use such urinary catheters, feeding tubes, and tracheostomy.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		3/14/25

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F 921	Continued From page 7 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 residents (R5) room was kept clean to reside in. Furthermore, the facility failed to maintain sanitary condition in the dining room. This had the potential to affect all 24 residents who ate food in the dining room. Findings include: During observation on 2/20/2025 10:34 a.m. to 11:35 a.m., a significant size of brownish stains were observed on the floor under a table close to the kitchen on three spots in the dining room. R5 stated it looked gross. Also observed were a few soiled tissues on the floor, uncleaned plate on two tables in the dining room with rest of scrambled eggs and pieces of bread. Six residents sitting two by two at the tables in the dining room. During observation on 2/20/25 at 11:42 a.m., the housekeeping supervisor (HS)-A cleaned the brownish stains under the table using washcloths without gloves on and then walked out of the dining room, did not wash hands, and touched a resident at the door who was asking for water. On 2/20/25 at 2:15 p.m. (HS)-A stated she was busy today and was not able to clean up the dining room right after breakfast. (HS)-A stated they have been trained to wear gloves when cleaning up dirt on the floor and wash hands. (HS)-A stated she should have cleaned the dining room just after breakfast and should have used	F 921	The process for satisfying this requirement has been reviewed and revised as necessary to ensure that sanitary conditions are maintained in resident rooms and the main dining area. R5 and other residents who eat in the main dining area have the potential to be affected. Areas identified in R5's room and the main dining areas were immediately cleaned. The policy and procedure for environmental cleaning has been reviewed and remains current. Education has been initiated for necessary staff regarding sanitation and cleaning standards / expectations. Audits will be completed to ensure compliance with this requirement. Audits will be completed three (3) times per week for two (2) weeks; weekly for two (2) weeks, monthly thereafter for one (1) month. Any deficient practice will be corrected at the time of occurrence, and results will be reviewed at QAPI. The Administrator or designee is responsible for compliance.	

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F 921	Continued From page 8 gloves when cleaning up the brownish stains under the table in the dining room. On 2/24/25 from 9:11 a.m. through 11:05 a.m. white powder like substance was observed scattered on the floor from the door to the sink area in R5's room. On 2/24/25 at 11:16 a.m. housekeeper (H)-B stated the white dirt on the floor came from R5's skin and she got busy and could not clean it up earlier. On 2/24/25 at 3:37 p.m. the director of nursing (DON) stated she expected the dining room to be cleaned before and after meals as well as resident's rooms. A facility policy, procedure, or schedule on routine cleaning non dated indicated housekeeping get assigned rooms and the dining room cleaning every day before and after meal throughout the facility.	F 921	Compliance date: 03/14/2025	

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Electronically delivered
March 6, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 4XJ411

Dear Administrator:

The above facility was surveyed on February 20, 2025 through February 24, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	C 02/24/2025

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 2/20/25 and 2/24/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H54597223C (MN00110543) H54597386C (MN00110619) with a licensing order issued at 4658 0800 Subp.3 and 4658. 1400. 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal protective equipment (PPE) was utilized for 3 of 4 residents (R1, R2, R4) reviewed for infection control concerns. Furthermore, the facility failed to ensure enhanced barrier precaution (EBP) [measure intended to prevent the spread of multi drug-resistant organisms] was implemented for 2 of 4 residents (R1, R4) reviewed for foley catheter cares. This had the potential to impact 20 residents with dressing changes, foley catheter, and tube feeding who resided on the unit. Findings include:	21385	corrected	3/14/25

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21385	Continued From page 3 R1 R1's Admission Record dated 6/21/2023, indicated R1's diagnoses included urinary tract infection, sepsis, and retention of urine. R1's quarterly Minimum Data Set dated 12/20/24, indicated R1 had intact cognition and required moderate assistance of two persons with an easy stand (EZ) for transfers. R1's care plan dated 12/20/24 indicated R1 had foley catheter, moderate assist for toilet hygiene with staff interventions included follow EBP direction while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities. On 2/10/25 at 00:50 a.m. a progress note indicated no output from catheter, R1 bypassing urine, foley catheter was removed and new 16 French with 10cc in balloon was placed. R1 tolerated the procedure and denied pain or discomfort. On 2/20/25 at 1:15 p.m. a progress note indicated a urologist had been notified about R1 recent hospitalization and her urinary tract infection (UTI) status. On 2/24/25 at 9:09 a.m., during an observation, R1 had her foley catheter under her wheelchair (w/c) but no EBP signage noted on her door. On 2/24/25 at 3:06 p.m. RN-A stated R1's room should have a signage since she had a foley catheter. RN-A stated they should have worn gowns and gloves when transferring R1 from the	21385		

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21385	Continued From page 4 chair to the bed. R2 R2's Admission Record dated 4/6/2024, indicated R2's diagnoses included bladder disorder and neuromuscular dysfunction of bladder. R2's care plan dated 4/6/2024 indicated R2 had indwelling foley catheter with staff interventions included follow EBP direction while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities. On 2/20/25 at 12:31p.m. nursing assistant (NA)-A and a licensed practical nurse (LPN)-A have been observed transferring R2 who had an indwelling foley catheter with Enhance Barriers Precaution (EBP) signage on the door without donning gown and gloves. NA-A removed the foley catheter from the chair to the bed without gloves on. NA-A then picked up from the floor the soiled linen left in the resident room and put it in the bag with no gloves on. A soiled brief was in the garbage can opened in the room and the bathroom. On 2/20/25 at 12:43 p.m. NA-A stated she did not know how long the soiled linen was on the floor in the resident's room nor the soiled briefs. NA-A confirmed R2 was on EBP due to the Foley catheter and staff were expected to wear gowns and gloves during high contact care including transfers, brief changes, and dressing changes. NA-A stated she should have put gown and gloves on when providing cares to a resident with a foley catheter with EBP on the door. On 2/24/25 at 10:54 a.m. NA-D brought R2 to his	21385		

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21385	Continued From page 5 room, NA-D did not wear gown or gloves. NA-D applied a transfer belt on R2, removed his foley catheter from the chair to the bed and called NA-E to help transferred R2 to bed which was high contact care activity. Both failed to wear gowns during the transfer with EZ. On 2/24/25 at 11:03 a.m. NA-D stated a gown and gloves were expected to be worn during transfers for residents on EBP. NA-D acknowledged she should have worn a gown and gloves while providing high contact care activity to R2. R4 R4's Admission Record dated 1/23/25, indicated R4's diagnoses included acute kidney failure, neoplasm of kidney, retention of urine, and infection inflammatory reaction due to indwelling urethral catheter. R4's care plan dated 1/23/25 indicated R4 had indwelling foley catheter with staff interventions included follow EBP direction while providing urinary catheter maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities. On 2/20/25 at 4:08 p.m. No signage of EBP on the R4's door noted. R4 had a foley catheter. NA-B and NA-C transferred R4 with no gowns and no gloves on. NA-B, after touching the foley catheter with no gloves on, went out to the clean utility to get a blanket for the resident without washing hands, and then took the resident to the dining room, touching the dining table where the resident was sitting. On 2/20/25 at 4:28 p.m. NA-B indicated any	21385		

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21385	Continued From page 6 resident with foley catheter should be on EBP and the staff was made aware by the signage on the door. NA-B verified R4 had a foley catheter and no precaution signage was on R4's door. On 2/20/25 at 4:30 p.m. NA-C stated she was not aware R4 was on EBP precautions and confirmed PPE was not worn during the care and transfers of R4. On 2/20/25 at 4:32 p.m. RN-B stated when a resident has a foley catheter, staff should put EBP signage on the door. RN-B did not know why R4 did not have EBP signage on his door. On 2/24/25 at 3:37 p.m. the director of nursing (DON), known also as the infection preventionist, stated R1 had recently been inserted a foley catheter back and should be on EBP precautions. The DON stated she was not aware about R1 change in condition. The DON stated she should have worn gloves and gown while caring for R1. The DON stated EBP signage should have been posted on R1's door. She expected all staff to be knowledgeable EBP and wear proper PPE when caring for residents on EBP precaution. The DON stated, she started a full house reeducation about infection control. The facility Enhanced Barrier Precaution policy dated 4/1/2024 indicated enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activities included dressing, transferring, changing linens, and device care or	21385		

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21385	Continued From page 7 use such urinary catheters, feeding tubes, and tracheostomy. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 residents (R5) room was kept clean to reside in. Furthermore, the facility failed to maintain sanitary condition in the dining room. This had the potential to affect all 24 residents who ate food in the dining room. Findings include: During observation on 2/20/2025 10:34 a.m. to	21665	corrected	3/14/25

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21665	Continued From page 8 11:35 a.m., a significant size of brownish stains were observed on the floor under a table close to the kitchen on three spots in the dining room. R5 stated it looked gross. Also observed were a few soiled tissues on the floor, uncleaned plate on two tables in the dining room with rest of scrambled eggs and pieces of bread. Six residents sitting two by two at the tables in the dining room. During observation on 2/20/25 at 11:42 a.m., the housekeeping supervisor (HS)-A cleaned the brownish stains under the table using washcloths without gloves on and then walked out of the dining room, did not wash hands, and touched a resident at the door who was asking for water. On 2/20/25 at 2:15 p.m. (HS)-A stated she was busy today and was not able to clean up the dining room right after breakfast. (HS)-A stated they have been trained to wear gloves when cleaning up dirt on the floor and wash hands. (HS)-A stated she should have cleaned the dining room just after breakfast and should have used gloves when cleaning up the brownish stains under the table in the dining room. On 2/24/25 from 9:11 a.m. through 11:05 a.m. white powder like substance was observed scattered on the floor from the door to the sink area in R5's room. On 2/24/25 at 11:16 a.m. housekeeper (H)-B stated the white dirt on the floor came from R5's skin and she got busy and could not clean it up earlier. On 2/24/25 at 3:37 p.m. the director of nursing (DON) stated she expected the dining room to be cleaned before and after meals as well as	21665		

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21665	Continued From page 9 resident's rooms. A facility policy, procedure, or schedule on routine cleaning non dated indicated housekeeping get assigned rooms and the dining room cleaning every day before and after meal throughout the facility. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure cleanliness of kitchen, dining room and residents room. a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		