DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 19, 2026

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

RE: CCN:245459
Cycle Start Date: May 1, 2026

Dear Administrator:

On May 1, 2026, 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 Supervisor, Federal 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 August 1, 2026 (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 1, 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

DEPARTMENT OF HEALTH

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Electronically delivered

May 19, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 22FF5C-H1

Dear Administrator:

The above facility survey was completed on May 1, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 Supervisor, Federal 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.

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

DEPARTMENT OF HEALTH

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Electronically Delivered
July 1, 2026

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

RE: CCN: 245459
Cycle Start Date: May 1, 2026

Dear Administrator:

On May 1, 2026, the Minnesota Department(s) of Health and Public Safety, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2026

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

Re: Reinspection Results
Event ID: 22FF5C-H1

Dear Administrator:

On June 16, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 1, 2026. 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

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 05/01/2026

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 4/28/26 through 5/1/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54598260C (2798540); H54591413 (2984785); H54591642C (2993367); and H54597906C (2793458) with citation issued at F842 and F725. 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.	F0000		06/08/2026
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F0725	The process for satisfying this requirement has been reviewed and revised as needed to ensure residents who are dependent on staff for activities of daily living (ADLs) are provided care and services in a timely manner. R1 was discharged from the facility. R5, R6, R8, and R9 all remain in the facility. R5, R6, R8, and R9 were all reviewed with no insufficient care or harm identified. All residents have the potential to be affected by this deficient practice. Call Light Policy and Facility Assessment reviewed with no changes. Staff to be educated on the facility's Call Light Policy and expectations of staff to ensure timeliness of call light response.	06/08/2026

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 05/01/2026

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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F0725 SS = E	Continued from page 1 care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure there are a sufficient number of nursing personnel to provide care and respond to each resident's basic needs as required by the resident's diagnoses or plan of care resulting in delayed responses to call lights and an inability to provide timely care. The failure affected multiple residents (R1, R5, R6, R8, R9) and placed all residents at risk for unmet care needs, avoidable discomfort, and potential decline. Findings include: R1's admission comprehensive Minimum Data Set (MDS) dated 4/13/26, indicated R1 had no cognitive impairment, was receiving diuretic medication, and required partial/moderate assistance with toileting and transfers. During an interview on 4/29/26 at 3:47 p.m., R1 stated when she pressed her call-light button, she sometimes had to wait at least an hour before anyone responded. R1 reported these delays made her feel as though staff had "forgotten about her." R1 further stated on one occasion she was experiencing shortness of breath (SOB) and waited approximately one hour before a nurse arrived. She reported the nurse provided a rescue inhaler rather than oxygen, which she believed would have helped increase her oxygen saturation level. R1 added call-light response times were even longer at night, and as a result, she tried not to use the call light unless absolutely necessary because she knew it would take a long time for staff to respond. Review of R1's facility call light log identified the following	F0725	Continued from page 1 DON or designee to conduct random call light audits. DON or designee to review daily staffing for sufficient staffing to staffing levels as determined by the Facility risk assessment/ and the residents' assessments and plan of care. Any identified non-compliance will be corrected at the time of occurrence. Audits to be conducted weekly times 4 weeks, then monthly times 2 months. Audit results will be reviewed by QAPI Committee for further recommendations.	06/08/2026

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 05/01/2026

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F0725 SS = E	Continued from page 2 • 4/3/26: Call at 7:05 a.m., answered at 8:21 a.m. (1 hour 16 minutes) • 4/1/26: Call at 10:12 p.m., answered at 11:05 p.m. (52 minutes) R5's admission comprehensive Minimum Data Set (MDS) dated 4/16/26, indicated R5 had no cognitive impairment, was receiving a diuretic medication, and required supervision or touching assistance with toileting and transfers and substantial/maximal assistance for sitting to stand. During an interview on 4/28/26 at 12:32 p.m., R5 stated he frequently waited extended periods after activating his call light, reporting wait times of "45 minutes or more" before staff responded. R5 explained the facility was short-staffed and often relied on agency personnel who "did not know our needs." R5 reported nursing assistants (Nas) had told him they were short-staffed and were doing "the best they could," but he stated the response times still took too long. R5 described feeling frustrated because staff often appeared rushed and unable to respond promptly to his needs Review of R5's facility call light log identified the following • 4/28/26: Call at 10:33 a.m., answered at 11:03 a.m. (30 minutes) • 4/24/26: Call at 10:40 a.m., answered at 11:15 a.m. (34 minutes) • 4/22/26: Call at 6:16 a.m., answered at 7:10 a.m. (54 minutes) • 4/17/26: Call at 12:28 p.m., answered at 1:20 p.m. (52 minutes) R6's quarterly comprehensive Minimum Data Set (MDS) dated 3/13/26, indicated R6's active diagnoses included congestive heart failure (CHF), hypertension, and diabetes Mellitus. Additionally, R6 had no cognitive impairment, was receiving a diuretic medication, was dependent on toileting hygiene, and transfers. During an interview on 4/28/26 at 1:12 p.m., R6 stated she avoided using the call light unless absolutely necessary because staff responses were consistently delayed. R6 explained many of the NAs	F0725		06/08/2026

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 05/01/2026

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F0725 SS = E	Continued from page 3 were still in school and the facility was short-staffed, though NAs were “doing what they could.” R6 reported her call-light wait times typically ranged from 30 minutes up to one hour. Review of R6’s facility call light log identified the following • 4/1/26: Call at 1:31 p.m., answered at 2:21 p.m. (50 minutes) • 4/10/26: Call at 8:44 p.m., answered at 9:45 p.m. (60 minutes) • 4/13/26: Call at 7:37 a.m., answered at 8:23 a.m. (46 minutes) • 4/17/26: Call at 7:07 p.m., answered at 8:08 p.m. (59 minutes) • 4/22/26: Call at 7:11 a.m., answered at 8:23 a.m. (1 hour 11 minutes) R8’s admission comprehensive Minimum Data Set (MDS) dated 11/17/25, indicated R8’s active diagnoses included CHF, hypertension, and renal failure. Additionally, R8 had no cognitive impairment and required substantial/maximal assistance for toileting and transfers. Review of R8’s facility call light log identified the following • 4/27/26: Call at 7:21 p.m., answered at 8:11 p.m. (50 minutes) • 4/25/26: Call at 8:32 p.m., answered at 9:17 p.m. (45 minutes) • 4/20/26: Call at 7:23 a.m., answered at 8:29 a.m. (66 minutes) • 4/4/26: Call at 7:06 p.m., answered at 8:49 p.m. (1 hour 42 minutes) R9’s quarterly comprehensive Minimum Data Set (MDS) dated 1/27/26, indicated R9’s active diagnoses included diabetes mellitus, hip fracture, and traumatic brain injury. Additionally, R9 had moderate cognitive impairment, and required partial/moderate assistance for toileting and transfers. During an interview on 4/29/26 at 11:58 a.m., R9	F0725		06/08/2026

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 05/01/2026

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F0725 SS = E	Continued from page 4 stated the call-light system was “a big issue” in the facility. R9 explained when staff were busy with other residents, her call light could remain on “for a while,” and she often had to wait at least an hour before anyone responded. R9 reported these delays caused her to feel uncomfortable and sad, describing situations where she had to sit in her own waste for extended periods while waiting for assistance. Review of R9’s facility call light log identified the following • 4/27/26: Call at 7:02 p.m., answered at 8:01 p.m. (59 minutes) • 4/15/26: Call at 7:09 a.m., answered at 7:58 a.m. (49 minutes) • 4/9/26: Call at 6:09 p.m., answered at 6:54 p.m. (44 minutes) • 4/4/26: Call at 7:02 p.m., answered at 8:01 p.m. (59 minutes) • 4/2/26: Call at 9:02 a.m., answered at 9:52 a.m. (50 minutes) During an interview on 4/28/26 at 1:28 p.m., nursing assistant (NA)-A stated the facility was short-staffed, especially during the evening and night shifts. NA-A explained they could not respond to call lights right away because “sometimes there were only two NAs for the whole facility.” NA-A reported that if they were assisting one resident, other call lights had to wait. Staff were trying to answer call lights as quickly as possible, but “there just were not enough of them on the floor” to respond promptly. During an interview on 4/30/26 at 12:11 p.m., NA-B stated she had been assigned to answer call lights and assist other staff as a float earlier that morning. NA-B stated a reasonable call-light response time should be 5 to 10 minutes. When multiple residents required assistance at the same time, call lights could remain unanswered for extended periods. NA-B frequently felt rushed and unable to respond promptly to all residents’ needs. NA-B stated staffing shortages had been an ongoing issue and that supervisors were aware of the problem. During an interview on 5/1/26 at 1:14 p.m., registered nurse (RN)-C stated she “never got time to get nursing tasks done” due to the workload and staffing levels. RN-C explained staff should answer	F0725		06/08/2026

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 05/01/2026

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F0725 SS = E	Continued from page 5 call lights immediately or within a reasonable timeframe. She reported call-light response times were often delayed because of insufficient staffing, particularly during the day and evening shifts. During an interview on 5/1/26 at 3:15 p.m., the Director of Nursing (DON) stated she expected staff to answer call lights immediately or within a reasonable timeframe. The DON explained the facility's goals were to reduce the number of call lights, decrease call-light wait times, and increase resident satisfaction. A recent call-light audit was requested from the facility but was not provided. Instead, the facility sent an email stating: "There was an ad hoc QAPI between the administrator and Clinical Leadership on 04/27/2026. An auditing process was determined at that time, and they were to be initiated on May 4th." The facility's Ad Hoc QAPI & Internal Four-Point Plan of Correction, dated 4/27/26, identified opportunities for improvement related to reducing the number of call lights, decreasing call-light wait times, and increasing resident satisfaction. The document cited several potential contributing factors, including lack of teamwork, lack of knowing the residents' transfer status, lack of availability to specific requiring extensive amount of time for assistance or the necessity for cares in pairs and not cancelling call light once in the resident's room. Policy regarding call light timely respond was requested and was not received.	F0725		06/08/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility	F0842	The process for satisfying this requirement has been reviewed and revised as needed to ensure resident skin assessments are completed and documented accurately. R7's skin assessments have been reviewed and plan of care has been updated. All residents have the potential to be affected by this deficient practice. Facility's Skin Assessment and Wound Management Policy was reviewed with no changes. The DON or designee will provide education to all appropriate staff on the facility's Skin	06/08/2026

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 05/01/2026

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
F0842 SS = D	Continued from page 6 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F0842	Continued from page 6 Assessment and Wound Management Policy, medical records accuracy an d completion of weekly skin inspections. The DON or designee will complete audits to ensure weekly skin inspections are complete and accurately documented. Any identified non-compliance will be corrected at the time of occurrence. Audits will be conducted weekly times 4 weeks, and then monthly times 2 months. Audit results will be reviewed by QAPI Committee for further recommendation.	06/08/2026

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F0842 SS = D	Continued from page 7 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards and practices for 1 of 3 residents (R7) reviewed for non-pressure related skin injuries. Findings include: R7’s order summary report dated 2/12/26, identified R7’s diagnoses included respiratory failure with hypoxia, a stage 3 pressure ulcer stage to spine, and colostomy/ileostomy. The order summary included an order for weekly skin inspection by licensed nurse every Monday on day shift. R7’s admission comprehensive Minimum Data Set (MDS) dated 2/9/26, indicated R1 had no cognitive impairment, was receiving surgical wound care, and required substantial/maximal assistance with toileting and transfers. Review of R7’s March and April 2026 Treatment Administration Record (TAR) showed check boxes indicating weekly skin check tasks were completed on 3/16/26, 3/23/26, and 4/13/26. However, there was no corresponding skin assessment documentation to support whether the assessments were completed. During an interview on 5/1/26 at 1:14 p.m., RN-C stated she cared for R7 on the evening shift of 3/23/26. RN-C confirmed she checked off the skin assessment task in the TAR but did not complete the skin assessment. RN-C explained she verbally passed the task to the night shift because she was behind on medication administration. RN-C stated she should have completed the skin assessment and documented the assessment, but “did not have time	F0842		06/08/2026

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F0842 SS = D	Continued from page 8 to get task done before the end of the shift". During an interview on 5/1/26 at 1:32 p.m., a licensed practical nurse (LPN)-A stated he cared for R7 on 3/16/26 but did not recall completing a skin assessment. LPN-A explained if the TAR indicated the task was completed, there should also be a corresponding skin assessment form in the record. During an interview on 5/1/26 at 3:15 p.m., the DON stated when a licensed nurse checked a box indicating a weekly skin check was completed, the nurse was also required to complete supporting documentation identifying the presence or absence of impaired skin integrity. The DON explained she was unable to locate documentation for R1's skin assessment dated 4/4/26, 4/11/26 and 4/25/26 or for R7's assessment dated 3/16/26, 3/23/26, and 4/13/26. The facility Skin Assessment and Wound Policy dated 2/2025 indicated a weekly skin inspection will be completed by licensed staff. Policy regarding resident medical records was requested and was not received.	F0842		06/08/2026

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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 4/28/26 through 5/1/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaints were reviewed: H54598260C (2798540), H54591413C (2984785), H54591642C (2993367), and H54597906C (2793458) with licensing orders issued at 20625. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal	20000		06/08/2026

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 **05/01/2026**

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		06/08/2026
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health	20625	Corrected.	06/08/2026

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20625	Continued from page 2 care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards and practices for 1 of 3 residents (R7) reviewed for non-pressure related skin injuries. Findings include: R7’s order summary report dated 2/12/26, identified R7’s diagnoses included respiratory failure with hypoxia, a stage 3 pressure ulcer stage to spine, and colostomy/ileostomy. The order summary included an order for weekly skin inspection by licensed nurse every Monday on day shift. R7’s admission comprehensive Minimum Data Set (MDS) dated 2/9/26, indicated R1 had no cognitive impairment, was receiving surgical wound care, and required substantial/maximal assistance with toileting and transfers. Review of R7’s March and April 2026 Treatment Administration Record (TAR) showed check boxes indicating weekly skin check tasks were completed on 3/16/26, 3/23/26, and 4/13/26. However, there was no corresponding skin assessment documentation to support whether the assessments were completed. During an interview on 5/1/26 at 1:14 p.m., RN-C stated she cared for R7 on the evening shift of 3/23/26. RN-C confirmed she checked off the skin assessment task in the TAR but did not complete the skin assessment. RN-C explained she verbally	20625		06/08/2026

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20625	Continued from page 3 passed the task to the night shift because she was behind on medication administration. RN-C stated she should have completed the skin assessment and documented the assessment, but “did not have time to get task done before the end of the shift”. During an interview on 5/1/26 at 1:32 p.m., a licensed practical nurse (LPN)-A stated he cared for R7 on 3/16/26 but did not recall completing a skin assessment. LPN-A explained if the TAR indicated the task was completed, there should also be a corresponding skin assessment form in the record. During an interview on 5/1/26 at 3:15 p.m., the DON stated when a licensed nurse checked a box indicating a weekly skin check was completed, the nurse was also required to complete supporting documentation identifying the presence or absence of impaired skin integrity. The DON explained she was unable to locate documentation for R1’s skin assessment dated 4/4/26, 4/11/26 and 4/25/26 or for R7’s assessment dated 3/16/26, 3/23/26, and 4/13/26. The facility Skin Assessment and Wound Policy dated 2/2025 indicated a weekly skin inspection will be completed by licensed staff. Policy regarding resident medical records was requested and was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to verifying and transcribing orders in the electronic medical record and/or develop a monitoring system to ensure resident records are true and accurate. The director of nursing or designee should educate staff and perform measurable audits. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		06/08/2026