



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
February 9, 2024

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

RE: CCN: 245459  
Cycle Start Date: January 25, 2024

Dear Administrator:

On January 25, 2024, a survey was completed at your facility by the Minnesota Department(s) 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 immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

#### **REMOVAL OF IMMEDIATE JEOPARDY**

On January 22, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

#### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

#### **SUBSTANDARD QUALITY OF CARE (SQC)**

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have

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received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Gardens At Winsted, LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 25, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### **DEPARTMENT CONTACT**

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

Terri Ament, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Duluth Technology Village  
11 East Superior Street, Suite 290  
Duluth, Minnesota 55802-2007  
Email: [teresa.ament@state.mn.us](mailto:teresa.ament@state.mn.us)  
Office: (218) 302-6151 Mobile: (218) 766-2720

**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.**

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

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Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

**[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov)**

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

#### **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://forms.web.health.state.mn.us/form/NHDisputeResolution>

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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](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,



Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Orville L. Freeman Building | HRD 3A 3rd Floor  
PO Box 64900  
625 Robert Street North  
St. Paul, MN 55155  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



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February 9, 2024

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

Re: Event ID: LJLW11

Dear Administrator:

The above facility survey was completed on January 25, 2024, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Holly Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Orville L. Freeman Building | HRD 3A 3rd Floor  
PO Box 64900  
625 Robert Street North  
St. Paul, MN 55155  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/25/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE GARDENS AT WINSTED LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>551 FOURTH STREET NORTH WINSTED, MN 55395</b>
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 1/24/24 through 1/25/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found to be IN compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H54598959C (MN00100105). A deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to the survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of non-compliance; however, the facility must acknowledge receipt of the electronic documents.</p>	F 000		
F 689 SS=J	<p><b>Free of Accident Hazards/Supervision/Devices</b> CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) who were at risk for elopement. This resulted in an immediate jeopardy (IJ) however, the facility implemented corrective action prior to the investigation so the deficiency remained at past non-compliance.</p>	F 689	<p>Past noncompliance: no plan of correction required.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>02/09/2024</b>
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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 689	<p>Continued From page 1</p> <p>The IJ began on 1/17/24 at 7:09 p.m. when the administrative hallway exit door alarm sounded and staff did not respond appropriately. At 7:36 p.m. R1 on was located outside, approximately 15 feet from the building. AccuWeather temperature identified it was between 10 degrees Fahrenheit (F) and -3 degrees F on 1/17/24. The facility administrator and director of nursing (DON) were notified of the IJ on 1/25/24 at 3:02 p.m. The facility had implemented corrective action on 1/22/24, prior to the start of the survey and was issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's Face Sheet printed 1/25/24, indicated diagnoses which included malignant neoplasm of the brain, and reduced mobility.</p> <p>R1's significant change Minimum Data Set (MDS) dated 12/12/23 indicated R1 had moderate cognitive impairment. The MDS also indicated R1 used a walker or wheelchair for mobility, and had a history of falls. The MDS indicated R1 did not have wandering behaviors.</p> <p>R1's Elopement Risk Assessment on 1/2/24 indicated he was at risk for elopement and aimlessly roamed in his wheelchair without a destination.</p> <p>R1's care plan dated 10/5/23, indicated R1 was at risk for elopement. R1 had a safety alarm bracelet (to alarm on certain doors to alert staff if he was trying to go out the door) on his left wrist. Interventions included the safety alarm bracelet would be monitored for proper functioning. and the door alarms would be answered promptly.</p>	F 689		

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F 689	<p>Continued From page 2</p> <p>On 11/14/23 a progress note indicated R1 had been noted to be wandering into empty rooms, and had been found sleeping in open beds.</p> <p>On 12/2/23 at 1:49 a.m., a progress note indicated R1 was up and wandering multiple times overnight. Staff attempted toileting and snack. R1 did not want to go to bed and was in the therapy lounge area. Shortly after staff left R1 alone, another resident called for help[, and staff found R1 lying in the other resident's bed. R1 was redirected back to his room and into bed.</p> <p>On 12/22/23 at 3:52 a.m., a progress note indicated R1 was up and wandering the hallways overnight. R1 attempted to enter other resident's rooms. R1 could not say what he was doing or if he needed anything. R1 was assisted back to his room multiple times. Staff also attempted offering a snack or toileting, but those interventions did not deter the wandering.</p> <p>On 1/17/24, at 11:45 p.m. a progress note indicated R1 exited the facility through the exit door in the administrative wing. R1's safety alarm bracelet did sound. R1 held the door until it opened. R1 stated he walked down the stairs and pulled his wheelchair with him. R1 stated he fell on the stairs and got back up and into his wheelchair. R1 exited the building through the exit door and was found by staff at approximately 7:35 p.m. R1 was able to walk up the stairs with 1 staff assist. An assessment completed at that time, and indicated R1 had full range of motion (ROM) to all extremities, no complaints of pain, neuro checks were stable. A skin check completed, with swelling noted and an abrasion on his left eye. R1 also had two scraped abrasions to the left</p>	F 689		

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F 689	<p>Continued From page 3</p> <p>mid/upper back approx 9 centimeters (cm) x 2 cm each. R1's left elbow was red with no noted swelling. Family contacted at 11:00 p.m. and did wish for R1 to be evaluated in the emergency room (ER) for any possible injury. R1 was sent to the ER for evaluation at 11:30 p.m.</p> <p>On 1/21/24 an Investigative Report Summary indicated at approximately 7:00 p.m. the alarm on the administrative hallway exit door sounded. NA-A responded to the alarm, and without looking outside, reset the alarm. The same door alarm went off again at approximately 7:10 p.m. NA-B looked around, and without looking outside, reset the alarm. At approximately 7:20 p.m. the door alarm went off again. At this time, RN-B and NA-A went to search for R1, and found him outside at approximately 7:30 p.m.</p> <p>On 1/24/24 at 2:48 p.m., RN-B stated she was working the evening of 1/17/24. RN-B stated she heard the door alarm around 7:00 p.m. RN-B stated it was unclear which door was causing the system to alarm and the door kept alarming, buzzing. RN-B stated around 7:30 p.m. she heard one of the nursing assistants looking for R1, and all staff began to search for him at that time. RN-B stated R1 was found outside just after 7:30 p.m. RN-B stated R1 appeared to have fallen at some point because he had a bump on his head and scrapes to his back.</p> <p>On 1/24/24 at 3:17 p.m., RN-A stated she was working the evening of 1/17/24. RN-A stated she heard someone ask if anyone knew where R1 was over the walkie-talkie. When she stepped out into the hallway, she could hear the alarm. RN-A stated she was unable to determine which exit door was going off. RN-A stated over the</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>walkie-talkie, staff were communicating areas of the facility that had been searched. RN-B stated she and NA-A went to the administrative hallway exit door. RN-A stated NA-A saw R1 outside, in his wheelchair, on the sidewalk. RN-A stated R1 had a bump over his eye. Due to R1 being mostly non-verbal, RN-A stated it was unclear if he had fallen. RN-A stated it was cold outside, and R1 was not wearing a coat.</p> <p>On 1/25/24 at 9:39 a.m., NA-B stated she was working the evening of 1/17/24. NA-B stated she heard the first door alarm around 7:00 p.m. She said NA-A cleared the alarm. NA-B stated about 10 minutes later, the door alarm was sounding again. NA-B stated she looked around, didn't see anyone, and she reset the alarm. NA-B stated around 7:30 p.m. NA-A called over the walkie-talkie to announce she couldn't locate R1. NA-B stated all staff began to search the building and then the outside premises. NA-B stated R1 was found outside by RN-A and NA-A, near the administrative offices exit.</p> <p>On 1/25/24 at 10:17 a.m., the DON stated when door alarms sounded, she expected the staff to open the doors to visualize outside. The DON drove to the facility and staff told her R1 had eloped. She noted it was 3 degrees Fahrenheit (F) when she got in her vehicle. The DON stated she immediately began re-education for the staff on resetting door alarms.</p> <p>On 1/25/24 at 10:53 a.m., NA-A stated she was working the evening of 1/17/24. NA-A stated she responded when the administrative hallway exit door alarm went off the first time. NA-A stated she looked around and didn't see anyone, so she reset the alarm to the door. NA-A stated when the</p>	F 689		

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F 689	<p>Continued From page 5</p> <p>alarm went off again, she and NA-B looked around, but did not see anyone and NA-B reset the door alarm. NA-A stated R1 was found outside around 7:30 p.m. Per AccuWeather the temperature was between 10 degrees Fahrenheit (F) and -3 degrees F on 1/17/24.</p> <p>On 1/25/24 at 11:17 a.m., the administrator stated when door alarms sound, staff should open the doors to observe for residents outside. The administrator stated only herself or her designee (who could be a licensed nurse, but not a nursing assistant) could reset the door alarms. The administrator stated re-education for the staff included resetting door alarms, a review of the elopement policy, and additional education of how the safety alarm bracelet system worked. The administrator stated the Quality Assurance Performance Improvement (QAPI) committee met to review the incident on 1/18/24. The administrator stated elopement drills were conducted on 1/18/24 and would continue to be conducted monthly. The administrator stated the State Fire Marshall was contacted and granted permission to extend the administrative office door alarm from 15 to 30 seconds. This was implemented on 1/24/24 by the director of maintenance.</p> <p>The facility Elopement Policy dated 6/23, directed staff to assure each resident is assessed on an ongoing basis and has appropriate safety precautions in place. The policy also directed only the administrator (or designee) may authorize disabling the door alarm system, and were responsible for the method of monitoring residents' safety and resetting the alarm.</p> <p>The past noncompliance immediate jeopardy</p>	F 689		

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F 689	Continued From page 6 began on 1/17/24. The immediate jeopardy was removed and the deficient practice corrected by 1/22/24, after the facility implemented a systemic plan that included the following actions: In a meeting held on 1/18/24 staff were retrained on the facility's elopement policy, with an emphasis on clearing alarms only to be conducted by leadership or nurses. Additional education was provided to all staff on the safety alarm bracelet system. Two elopement drills were conducted with staff on 1/18/24. Verification of staff signatures on education provided reviewed. On 1/24/24, the administrative office door emergency release extended from 15 seconds to 30 seconds. Verification of corrective action was confirmed by observation, interview, and document review on 1/24/24 and 1/25/24.	F 689		