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	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens at Winsted LLC	551 Fourth Street North Winsted, MN 55395

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review the facility failed to notify the resident's representative following resident change of condition for 1 of 1 resident (R1) who had a decline in condition resulting in hospitalization . Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment. R1's diagnoses included diabetes, morbid obesity, anemia, edema, heart failure, altered mental status, and end stage renal disease. R1 was dependent on staff for dressing, toileting, personal hygiene, transferring, and bed mobility. The MDS also identified R1 had two stage 2 pressure ulcers (presenting as a shallow open ulcer); three stage 3 pressure ulcers (full thickness tissue loss which may include undermining or tunneling) and one unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar). R1's physician orders included: - Tylenol 1000 mg by mouth three times daily for pain; Tramadol 50 mg by mouth every six hours as needed for severe pain (start date 4/3/24). -Wound culture to coccyx ulcer for wound infection; turn resident every two hours; keep all pressure off his coccyx; up to chair only for meals; complete blood count (CBC) for wound infection; Cephalexin 500mg QID for 7 days for wound infection (start date 4/15/24). -Discontinue cephalexin (antibiotic); start Augmentin (antibiotic) 875mg/125mg one (1) tab twice daily for 10 days for wound infection (start date 4/19/24). R1's medical record lacked documentation of notification of physician order changes to R1's responsible party on 4/3/24, 4/15/24, and 4/19/24. During interview on 5/13/24 at 2:20 p.m., family member (FM)-A stated she was the responsible party and primary contact for R1. Indicated R1 was hospitalized on [DATE] because of an infected ulcer on his tailbone. Further indicated she was unaware that the wound had deteriorated to the extent that it had, and the facility did not notify her of any changes in R1's wounds. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/14/24 at 1:33 p.m., FM-A indicated the facility had not notified her of any of the new orders for antibiotics or pain medications and was unaware until this phone interview. During interview on 5/14/24 at 10:40 a.m., licensed practical nurse (LPN)-A stated R1 had chronic medical issues and did not call the family or responsible party on all of the physician order changes. Stated she was aware of R1's orders for antibiotics but did not call the family. LPN-A further stated it would be unrealistic to call the families about wound care orders. During interview on 5/14/24 at 1:51 p.m., registered nurse (RN)-A indicated the policy directed to call with all order changes but was not sure if the policy addressed change of resident condition. Further stated, they (nurses) are supposed to call the resident's responsible person or family member with any order changes but admitted that she should be better at that. During interview on 5/14/24 at 2:26 p.m., RN-B indicated nurses should be calling families for a resident's change in condition, fall, become more confused. Further stated, it is the doctor's job to talk to the responsible party about medication changes. I am not aware that we have to call. During interview on 5/14/24 at 2:33 p.m., RN-C indicated they (nurses) call the responsible party if there is a fall but do not call the responsible party for medication changes. During interview on 5/14/24 at 12:06 p.m., the director of nursing (DON) indicated her expectation was nursing staff contact families for a new or worsening wound, new medications, and medication changes. The facility's Notification of Changes Policy dated 3/2024, indicated it is the policy of the facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment, and preferences to address the changes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review the facility failed to effectively monitor and communicate wound status for early recognition of changes on 1 of 2 residents (R1) reviewed for worsening pressure ulcers. Findings include: R1's significant change in status Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment. R1's diagnoses included diabetes, morbid obesity, anemia, edema, heart failure, altered mental status, and end stage renal disease. R1 was dependent on staff for dressing, toileting, personal hygiene, transferring, and bed mobility. The MDS also identified R1 had two stage 2 pressure ulcers (presenting as a shallow open ulcer); three stage 3 pressure ulcers (full thickness tissue loss which may include undermining or tunneling) and one unstageable pressure ulcer (known but not stageable due to coverage of wound bed by slough and/or eschar). R1's care plan initiated on 8/16/23, indicated R1 had skin alterations to coccyx, rear right thigh, left 2nd toe, and left heel. Directed nursing staff to document on skin condition, monitor for skin breakdown for signs/symptoms of infection, and to keep medical doctor (MD) or physician's assistant (PA) informed of changes. R1's wound care note dated 4/8/24, indicated R1 had a stage 3 pressure ulcer on the left heel, stage 3 pressure ulcer on coccyx, stage 3 pressure ulcer left ischial tuberosity (sit bones), stage 3 on right rear thigh, and a new unstageable perianal pressure ulcer due to a medical device. R1's Treatment Administration Record (TAR) identified daily and as needed wound treatments for the rear right thigh pressure ulcer, left 2nd toe, and left heel. The TAR identified twice daily and as needed wound treatments for the perianal pressure ulcer. R1's wound care noted dated 4/29/24, indicated R1 was being treated for the following wounds: 1) unstageable pressure ulcer on the left heel measured 2.9 centimeters (cm) in length x 1.7 cm wide. 2) Venous ulcer 2nd toe dorsal left measured 0.8 cm in length x 0.4 cm wide. 3) unstageable pressure ulcer perianal measured 4.7 cm in length x 3.4 cm wide 4) unstageable pressure ulcer rear right thigh measured 1.4 cm in length x 0.6 cm wide. R1's Progress Notes dated 5/2/24 at 10:57 p.m., indicated R1 was lethargic, non responsive and taken to the emergency room by ambulance. R1's Progress Noted dated 5/3/24 at 8:23 p.m., indicated R1 was admitted to the hospital due to sepsis (infection in the blood) due to infection of the perianal wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24 at 10:21 a.m., the nurse manager stated she manages the wounds along with an outside wound care agency. Indicated nurse's do weekly skin checks and if any alteration in skin status is noted, she was notified for follow-up. Further indicated it was then referred to the wound care agency and came weekly to assess the wound, gave wound orders, and reviewed interventions. Facility nursing staff were expected to carry out the wound orders as written. Further stated that although the nurse's visualize the wounds during dressing changes, the facility does not have a good process for documenting the monitoring of the wounds. Stated, it is an area we need to work on. During an interview on 5/14/24 at 10:40 a.m., licensed practical nurse (LPN)-A indicated the nurse's do twice daily wound treatments to R1's wounds and visualize them at that time. If the wound got worse or it showed signs of infection, they would call the doctor and document it. Verified R1 did not have any wound progress notes in the medical record from 4/23/24 to the date of R1's hospitalization for wound infection on 5/2/24. LPN-A indicated it could not be ascertained if/when the wounds changed because there was not documentation to compare. During an interview on 5/14/24 at 1:50 p.m., RN-A indicated she performed routine wound treatments but did not document the condition of the wound in the medical record unless it looked different from her last observation. Further indicated she does not work every day and would not know what the previous nurse observed if it was not documented. RN-A stated she would not know if it changed from one day to the next unless it was in the medical record. During an interview on 5/14/24 at 12:05 p.m., the director of nursing (DON) indicated nurses observe resident wounds when doing wound treatments but did not expect them to document the condition of the wound unless it changes. Wound care comes in weekly to assess the wounds and adjust any orders as needed. Verified R1's wound status was not documented in the medical record except for the wound care provider. Confirmed that the nurse would not know the condition of the wound on the previous shifts without documentation. The facility policy titled, Wound Care Treatment Procedure dated 2/2024 instructed for every wound dressing change to evaluate the wound and note if there is any presence of possible complications such as: increasing are of skin damage, increased redness or swelling around the wound, pain, an increase in drainage from the wound and the characteristics of the drainage (odor, color, consistency). If there are any changes to the resident's wound appearance, pain, ability to tolerate the dressing change, or resident refusal; notify the provider immediately to collaborate on a new plan of care/treatment.