

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER The Gardens at Winsted LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20794</p> <p>Based on observation, interview and document review, the facility failed to ensure resident's ordered medications were fully communicated to the filling pharmacy. In addition, the facility failed to ensure all licensed staff (including pool agency staff) understood and utilized the emergency medication kit (E-Kit) for 1 of 3 residents (R1) who did not have all physician ordered medications delivered from pharmacy for continuity of care.</p> <p>Findings include:</p> <p>R1's Active Diagnosis listing documented the following diagnoses: acute and chronic congestive heart failure, type 2 diabetes (insulin dependent), asthma and morbid obesity due to excess calories. R1's minimum data set (MDS) was still in process due to R1's admission on 12/24/24. However, the facility had performed a Brief Interview for mental Status (BIMS) with R1, dated 12/24/24 and found to have scored 15 (cognitively intact).</p> <p>In review of R1's Clinical Profile (Face Sheet), R1 was admitted to the facility on [DATE] from Ridgeview Hospital Waconia. The hospital sent, both before and upon the admission process of R1, medication and treatment orders for continuity of R1's care.</p> <p>A review of R1's scanned orders (dated 12/24/24), the facility placed checks next to each medication and treatment order, question marks next to orders needing clarification from the prescribing physician. The facility staff utilized this process in placing R1's orders and treatments in to the Point Click Care system (electronic medication record).</p> <p>R1's progress notes were reviewed. The following medications were not filled by pharmacy immediately following R1's admission to the facility. The following entries were noted:</p> <p>12/24/2024 22:35 (10:35 p.m.)</p> <p>Note Text: Nystatin External Powder 100000 UNIT/GM (Gram)</p> <p>Apply to skin topically two times a day for Infection Mix with Triad and apply to Skin fold/under pannus/into groin between legs.</p> <p>coming from pharmacy</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/24/2024 22:35 (10:35 p.m.)</p> <p>Note Text: Torsemide Oral Tablet</p> <p>Give 100 mg (milligrams) by mouth two times a day related to HEART FAILURE, EDEMA. coming from pharmacy</p> <p>12/24/2024 22:35 (10:35 p.m.)</p> <p>Note Text: Triamcinolone Acetonide External Cream 0.1 %</p> <p>Apply to Skin topically two times a day. Apply a thin layer to entire outer layer of skin in the genital area where new tunnels are forming. coming from pharmacy</p> <p>12/24/2024 22:35 (10:35 p.m.)</p> <p>Note Text: Montelukast Sodium Oral Tablet</p> <p>Give 10 mg by mouth at bedtime related to UNSPECIFIED ASTHMA, UNCOMPLICATED. coming from pharmacy</p> <p>12/24/2024 22:34 (10:34 p.m.)</p> <p>Note Text: Pantoprazole Sodium Oral Tablet Delayed Release</p> <p>Give 40 mg by mouth in the evening related to GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS for 90 Days Do not crush. Take on an empty stomach at least 30 minutes before a meal or at bedtime coming from pharmacy</p> <p>12/24/2024 22:34 (10:35 p.m.)</p> <p>Note Text: Breztri Aerosphere Inhalation Aerosol 160-9-4.8 MCG (micrograms)/ACT</p> <p>2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED coming from pharmacy</p> <p>12/24/2024 22:34 (10:35 p.m.)</p> <p>Note Text: Insulin NPH (Human) (Isophane) Subcutaneous Suspension Pen-injector 100 UNIT/ML</p> <p>Inject 25 units subcutaneously in the evening related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION With supper</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>coming from pharmacy</p> <p>12/24/2024 22:34 (10:35 p.m.)</p> <p>Note Text: Atorvastatin Calcium Oral Tablet</p> <p>Give 80 mg by mouth in the evening related to HYPERLIPIDEMIA</p> <p>coming from pharmacy</p> <p>In further review of R1's orders received at admission on 12/24/24, the facility had been waiting for clarification on R1's sliding scale insulin to be clarified. The hospital sent the following order for R1's sliding insulin scale:</p> <p>insulin aspart 100 UNIT/ML injection Commonly known as: NovoLOG Dose: 1-32 Units Subcutaneous, WITH MEALS AND BEDTIME. Blood Glucose Target - Daytime (mg/dL): 153 Blood Glucose Target - Bedtime and Overnight (mg/dL): 185 Hyperglycemia Correction Factor - Daytime: 15 Hyperglycemia Correction Factor - Bedtime and Overnight: 30</p> <p>This order failed to delineate the number of insulin units to be given for a given blood sugar range. Only to give 1 - 32 units of insulin aspart 100 units/ml with meals and bedtime.</p> <p>During interview on 1/2/25 at 2:02 p.m., director of nursing (DON) and resident care manager (RCM) were interviewed. The DON stated she became aware of the above documented medication not being delivered on 12/25/24. Working with the licensed staff that day, they contacted the pharmacy and again electronically sent the orders for the missing medications. DON was told by the pharmacy they had only filled the medications on the pages received, 8 in total. RCM was in the facility on 12/24/24 when R1 was admitted and assisted with the review of R1's ordered medications and communication to the filling pharmacy. Both the DON and RCM stated the facility utilized a PIXUS medication dispensing system and a refrigerated E-Kit (located in a locked medication room) in case a resident's medications had not been ordered or the pharmacy had yet to deliver resident's medications. Both nurses indicated most of the medications identified above could have been obtained from the PIXUS / E-Kit. For medications not included in these two systems a STAT order to the pharmacy could have been done by the scheduled licensed staff. Both nurses stated the ordering physicians refused to clarify the sliding scale orders, leaving it for the primary physician to deal with at a later time.</p> <p>In review of R1's blood sugar records, the following was noted:</p> <p>12/26/2024 13:13 434.0 mg/dL</p> <p>12/26/2024 11:20 434.0 mg/dL</p> <p>12/25/2024 20:51 442.0 mg/dL</p> <p>12/25/2024 09:17 291.0 mg/dL</p> <p>12/24/2024 20:06 213.0 mg/dL</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/24/2024 17:03 189.0 mg/dL</p> <p>During a telephone interview on 1/2/25 at 3:08 p.m., pharmacist (PharmD) with Polaris Pharmacy (St. Louis Park, MN) stated, according to their records they had only received 6 pages of R1's medication and treatment orders from the facility. PharmD stated the pharmacy delivers twice a day, however only once a day on holidays. PharmD further stated, should the facility have called a STAT order to their services, they could have had the medications to the facility within 4 hours. PharmD stated their company runs 24 hours a day, 7 days a week.</p> <p>In further interview on 1/2/25 at 3:17 p.m., DON stated the facility utilized pool agency staff during relief shift on 12/24/24 and both day and relief shifts on 12/25/24. DON stated both she and the RCM take turns being on call during the holidays and weekends, and neither had received a call in regards to R1's medications not being delivered in full, until the morning of 12/25/24. DON stated when the day shift pool staff nurse (RN)-A contacted her, she assisted RN-A to contact the pharmacy and re-send R1's orders. DON stated the facility staff have access to the PIXUS system, however the agency pool staff do not. The facility created a systems tree for the pool staff, which is covered during their initial orientation to the facility. The system tree illustrated how pool staff were to deal with missing medications and / or medications which have yet to arrive to the facility from pharmacy. DON stated should a medication be needed from the secured PIXUS system, the pool staff were to call the oncall nurse to obtain the medication for the resident in need. However, in the case of R1's insulin, located in the refrigerated E-Kit, the pool staff failed to check this location. In not checking the E-Kit, R1 missed her evening dose of insulin on 12/24/24 and morning dose on 12/25/24. The facility identified the medication errors and had contacted the provider, with facility staff educated on the ordering of medications.</p> <p>Attempts were made, both on 1/2/25 and 1/3/25, to contact the schedule pool agency staff: licensed practical nurse (LPN)-A for the relief shift on 12/24/24, and RN-A who covered both the day and relief shift on 12/25/24, with no response back from either.</p> <p>During a follow-up interview on 1/2/25 at 3:58 p.m., PharmD was asked specifically, if the missing of R1's two doses of insulin would been a significant error. PharmD, after review of R1's blood sugars and historical information, stated the omission of the two doses of insulin were not a significant medication error due to her more historic higher blood sugar levels. And with the insulin being received by the facility on 12/25/24, and no change in R1's overall condition, it was not a significant omission.</p> <p>In a telephone interview on 1/2/25 at 3:52 p.m., physician assistant (PA), who performs the weekly facility rounds (three times a week) for R1's primary physician, stated she first met with R1 on 12/26/24 during rounds. PA stated she clarified the sliding scale orders the hospital failed to do, and has been adjusting resident's regularly scheduled insulin doses since admission. PA stated R1 has a history of non-compliance with her type 2 diabetes, normally running in the 300's or more. R1 was hospitalized after a fall at home and it was found she was experiencing a bladder infection. Although the facility failed to follow up on the scheduled insulin order, PA did not feel the omission of the two doses (evening of 12/24/24 and AM of 12/25/24) were significant. In review of R1's blood sugar readings, during the time of the omissions, R1's blood sugars were lower than normal. The PA noted the two 400 readings, noted on 2/26/24 were the the day she clarified R1's sliding scale. PA stated her blood sugar levels, now that she is in the facility, are coming down and R1's nutritional intake is better monitored.</p> <p>(continued on next page)</p>		

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