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	08/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to maintain residents' dignity for 2 of 3 residents (R4, R5) reviewed for dignity when it took 20 minutes for staff to answer call lights causing R4 and R5 to become incontinent. Findings included: R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact. R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. It also indicated R4 was on diuretic and BPH medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours. R4's annual Minimum Data Set (MDS) dated [DATE] indicated he had diagnoses of heart failure, benign prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status. R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated R4 stated he only had incontinent episodes if staff cannot answer his call light. R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate. The device activity report indicated R4 had his call light on for 20 minutes, starting at 1:40 p.m., on 8/14/25. On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes, leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination. R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated [DATE], indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. The device activity report indicated R5 had his call light on for 20 minutes, starting at 1:40 p.m., on 8/14/25. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, I don't like sitting in wet pants. R5 stated, This happens often, and that it occurs more often late in the evening and in the middle of the night. On 8/15/25, at 10:10 a.m., the director of nursing (DON) stated she expected call lights to be answered as soon as possible, but within 15 minutes. She stated toileting schedules should be implemented for R4 and R5 to promote continence. On 8/15/25, at 11:50 a.m., the administrator stated the NA's should be answering call lights within 15 minutes. A facility document, Activities of Daily Living (ADLs) Maintain Abilities Policy, dated 3/31/23, directed It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to develop and implement interventions to maintain continence for 2 of 3 residents (R4, R5) reviewed for care plans. Findings include: R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact. R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. R4 was on diuretic and benign prostate hyperplasia (BPH) medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours. R4's annual Minimum Data Set (MDS) dated [DATE] indicated he had diagnoses of heart failure, benign prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status. R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated he stated he only had incontinent episodes if staff cannot answer his call light. R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate. On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes, leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination. R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated [DATE], indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, I don't like sitting in wet pants. R5 stated, This happens often, and that it occurs more often late in the evening and in the middle of the night. R5 stated he was not on a toileting schedule. On 8/14/25, at 4:43 p.m., NA-A stated residents who cannot use their call lights are on toileting schedules every two hours She stated all other residents use their call light when they need to use the restroom and call lights are answered in the order they are pressed. She stated R4 and R5 were assisted to the bathroom as they requested it and were not on a schedule. On 8/15/25, at 9:48 a.m., NA-C stated R4 and R5 were supposed to be on a toileting schedule on the odd hours, but it was not followed. She stated it was implemented by the previous director of nursing (DON). On 8/15/25, at 10:10 a.m., the DON stated toileting schedules were intended to prevent incontinence episodes, by assisting the resident to the restroom on a regular basis and promote continence. She stated R4 was on a toileting schedule every two

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure residents incontinent of bladder and bowel received services to maintain continence when 2 of 3 residents (R4, R5) reviewed for continence care did not receive timely care, resulting in bladder incontinence. Findings include: R4's care plan, dated 4/29/25, indicated R4 was frequently incontinent of bladder and occasionally incontinent of bowel. It also indicated R4 was on diuretic and BPH medications. The care plan directed he required assistance of two staff with full ceiling lift, provide assistance with peri cares, provide incontinent products, and assist to change as needed. The care plan directed a toileting schedule of every two hours on the odd hour, during waking hours. R4's Brief Interview for Mental Status (BIMS), dated 4/11/25, indicated he was cognitively intact. R4's annual Minimum Data Set (MDS) dated [DATE] indicated he had diagnoses of heart failure, benign prostatic hyperplasia (BPH, an enlarged prostate gland), hemiparesis (weakness on one side), and morbid obesity. The MDS indicated he was dependent on staff for assistance with toileting and personal hygiene, as well as transfers from bed to chair and from the chair to the bed. The MDS indicated a toileting program had not been trialed for R4. The MDS did not assess R4's cognitive status. R4's bladder and bowel assessments, dated 7/9/25, indicated he was continent of bladder and bowel. It indicated he stated he only had incontinent episodes if staff cannot answer his call light. The assessment lacked pertinent diagnoses that may affect urinary function, identification of medications related to urinary urgency and frequency, voiding patterns. The assessments lacked interventions to manage R4's incontinence.R4's care area assessment (CAA), dated 7/18/25, indicated R4 triggered for need for assistance with toileting and urinary incontinence. The CAA indicated R4 was frequently incontinent of bowel and bladder. The CAA indicated staff will continue to follow current care plan to aide in prevention of complications of incontinence including assistance with managing incontinent products, assisting with toileting needs as he requests/allows monitoring for signs and symptoms of infection and assisting with peri cares as appropriate. On 8/14/25, at 2:30 p.m., R4 stated he had an incontinent episode after waiting for staff to respond to his call light. He stated his call light had been on for 20 minutes. R4 stated call wait time were always long, adding at times it took over an hour for the staff to respond to his call light. R4 stated this resulted in him having more incontinence episodes, leaving him to feel uncomfortable and as if the staff does not care about him. R4 stated he had been on diuretics for five years which creates more urgency and frequency during the morning hours. He stated long call wait times had been addressed through grievances and at the resident council meetings. He stated he was not on a toileting schedule but had been in the past. R5's CAA, dated 9/12/24, indicated R5 was incontinent, wore incontinence products, would call for assistance to the toilet, and was taking a diuretic plus medications to help with urination. R5's bladder assessment, dated 12/27/24, indicated he was frequently incontinent of bladder, was able to make his needs known, required assistance of one staff for transfers. The assessment indicated it was not appropriate for a bladder retraining program. R5's bowel assessment, dated 12/27/24, indicated he was continent of bowel and transferred with the assistance of one staff. R5's quarterly MDS, dated [DATE], indicated had heart disease, renal insufficiency, and BPH. The MDS indicated he was cognitively intact and required partial to moderate assistance with personal and toileting hygiene. The MDS indicated R5 used his wheelchair independently and was independent with transfers from the chair to the bed and from the chair to the toilet. The MDS indicated R5 was always incontinent of urine and always continent of bowel. It also indicated no trial of a toileting program had been implemented or trialed for R5. R5's care plan, dated 8/5/25, indicated he had alteration in elimination related to impaired mobility. The care plan directed assistance of one staff to/from toileting, assist with peri cares, provide incontinent products, and assist to change as needed. On 8/14/25, at 2:40 p.m., R5 stated he had been waiting for a half an hour when the NA responded to his call light at 2:00 p.m. He stated when he pressed the call light, he had not been incontinent yet, but due to the wait he urinated in his brief. R5 stated this made him feel anxious and mad. He also stated, I don't like sitting in wet pants. R5 stated, This happens often, and that it occurs more often late in the evening and in the middle of the night. R5 stated he was not on a toileting schedule. On 8/14/25, at 4:43 p.m., NA-A stated residents who cannot use their call lights are on toileting schedules every two hours She stated all other residents use their call light when they need to use the restroom and call lights are answered in the order they are pressed. She stated R4 and R5 were assisted to the bathroom as they requested it and were not on a schedule. On 8/15/25, at 9:48 a.m., NA-C stated R4 and R5 were supposed

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and document review the facility failed to ensure the facility assessment included the required components of involvement from direct care staff, considering staffing needs of each unit in the facility, and a plan to recruit and retain staff. This had the opportunity to affect all 33 residents. Findings include: Review of the facility assessment, dated 7/22/24, failed to include input and active involvement from direct care staff, including but not limited to registered nurses (RN), licensed practical nurses (LPN), and nursing assistants (NA). The document indicated the following people were involved in completing the assessment: administrator, director of nursing (DON), Governing Body representative, the medical director, the pharmacist, and residents/resident representatives/family members through letters, family council and resident council. The facility assessment failed to consider staffing needs for each unit in the facility and failed to consider staffing needs for each shift. The document indicated acuity needs of residents was reviewed and evaluated regularly and determined by resident assessments, care plans, and census. The staffing plan section of the document indicated staffing needs were determined by reviewing the resident population, case mix index (CMI) and census daily. Admissions and discharges assist in determining staffing needs for each day. The facility assessment lacked a plan and maximized recruitment and retention of direct care staff. It also lacked a contingency planning for events that did not require activation of facility's emergency plan, but had the potential to affect resident care, such as availability of direct care nurse staffing or other resources for resident care. The facility daily schedules from 7/15/25 through 8/14/25 indicated the facility staffed nurses and trained medication aides (TMA) for the north and south units. The facility staffed NAs for rooms 200-224, rooms 207-225 and 226-228, 229-244, and a float aide. (Actual room layout is not in numerical sequence.) Facility call light records reviewed for 4 residents from 7/15/25 through 8/14/25 identified excessive call light wait times, with the longest response time of 120 minutes. The review identified the following: 115 call light wait times that exceeded 20 minutes 28 call light wait times that exceeded 30 minutes 50 call light wait times that exceeded 40 minutes 3 call light wait times that exceeded 50 minutes 4 call light wait times that exceeded 60 minutes 2 call light wait times that exceeded 70 minutes 2 call light wait times that exceeded 80 minutes 1 call light wait times that exceeded 90 minutes 1 call light wait time was exceeded 120 minutes On 8/14/25, at 8:10 a.m., family member (FM)-A stated family felt uncomfortable leaving R1 at the facility without their presence due to the facility's slow response time to the call light. FM-A stated they often waited for 40 minutes for the staff to answer the call lights. On 8/14/25, at 1:11 p.m., FM-B stated it was common to wait 45 minutes for R1's call light to be answered. On 8/14/25, at 2:06 p.m., R3 stated she has had to wait for over two hours at times for her call light to be answered, resulting in her sitting in feces, due to the facility cutting staff. On 8/14/25, at 2:30 p.m., R4 stated call wait times were addressed with the facility management through resident council meetings and their response was they had the right number of staff they were required to have. He stated, There just aren't enough people. He also stated he always experienced long call light wait times. R4 stated he pressed his call light at 1:40 p.m., on 8/14/25, to use the commode. He stated he had become incontinent while waiting for staff assistance, which took 20 minutes. On 8/14/25, at 2:40 p.m. R5 stated he put his call light on around 1:30 p.m., on 8/14/25. He stated he had not been incontinent when he first pressed his light, but due to waiting for over 30 minutes, he urinated in his brief. R5 stated it happened often, as the facility was short-staffed, and the wait was worse overnight. On 8/14/25, at 2:55 p.m., R6 stated call wait times were very long. She stated at the last resident council meeting another resident stated he had waited over 2 1/2 hours for his call light to be answered. On 8/14/25, at 4:43 p.m., NA-A stated the facility was cutting staff, due to empty beds in the facility. She stated, One person has to go home at 9:00 p.m. She stated the staff has attempted to address their staffing concerns with management, but felt management did not care. On 8/14/25, at 4:48 p.m., NA-B stated, I feel like a lot of call lights are on for a long time, it's been busy, and residents are waiting. She also stated one NA has to leave the shift early, at 9:00 p.m. NA-AD stated some of the residents had complained about the response time to the call lights. NA-AD stated several residents required the assistance of two staff for transfers. On 8/14/25, at 4:53 p.m., RN-A stated she did not feel the facility had enough staff. She said the residents had to wait for their call lights to be answered, causing them to be incontinent by the time the staff responded. RN-A stated residents had complained about the length of time they had to wait. She stated it was hard when one of the NA's was required to leave at 9:00 p.m., due to low census. RN-A stated she shared these concerns with management. On 8/15/25, at 8:30 a.m., the staffing coordinator (SC) stated the