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	05/01/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 callˆlight 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 callˆlight 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 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 [DATE], 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 shortˆstaffed and often relied on agency personnel who did not know our needs. R5 reported nursing assistants (Nas) had told him they were shortˆstaffed 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 needsReview 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 [DATE], 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 were still in school and the facility was shortˆstaffed, though NAs were doing what they could. R6 reported her callˆlight 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., (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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE], 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 [DATE], 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 stated the callˆlight 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)ˆA stated the facility was shortˆstaffed, especially during the evening and night shifts. NAˆA explained they could not respond to call lights right away because sometimes there were only two NAs for the whole facility. NAˆA 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., NAˆB stated she had been assigned to answer call lights and assist other staff as a float earlier that morning. NAˆB stated a reasonable callˆlight 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. NAˆB 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)ˆC stated she never got time to get nursing tasks done due to the workload and staffing levels. RNˆC explained staff should answer call lights immediately or within a reasonable timeframe. She reported callˆlight 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 callˆlight wait times, and increase resident satisfaction.A recent callˆlight 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 Fourˆ Point Plan of Correction, dated 4/27/26, identified opportunities for improvement related to reducing the number of call lights, decreasing callˆlight 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 [DATE], 4/11/26 and 4/25/26 or for R7's assessment dated [DATE], 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.