

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/24/2026
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)		
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 document review, the facility failed to ensure residents' call lights were responded to timely to meet resident needs for 5 of 6 residents (R4, R6, R13, R20, and R38) reviewed for call light response times. This failure resulted in residents experiencing prolonged wait times for assistance and placed residents at risk for unmet care needs, including toileting, hygiene, and other requests for assistance. Findings include: R4's quarterly Minimum Data Set (MDS), dated [DATE], indicated R4 was cognitively intact, and diagnoses included chronic respiratory failure, heart failure, and anxiety disorder. R4 had lower extremity impairment on both sides, used a wheelchair, was dependent on staff for dressing, transfers, and toileting, and was frequently incontinent. During an interview on 7/20/25 at 2:23 p.m., R4 stated she was concerned about long call light times. During an interview on 7/22/26 at 3:56 p.m., nursing assistant (NA)-C stated R4 used her call light frequently and required the assistance of 2 staff with transfers with a mechanical lift. Review of R4's call light logs from 6/21/26- 7/22/26, identified multiple call light response times greater than 30 minutes: 6/24/26 at 12:51 p.m. - response time 44 minutes 6/25/26 at 5:47p.m. - response time 68 minutes 6/25/26 at 8:11 p.m. - response time 61 minutes 6/27/26 at 6:21 p.m. - response time 33 minutes 6/28/26 at 10:37 a.m. - response time 44 minutes 6/28/26 at 6:57 p.m. - response time 57 minutes 6/28/26 at 8:43 p.m. - response time 39 minutes (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	6/29/26 at 6:34 a.m. - response time 55 minutes 6/29/26 at 12:49 p.m. - response time 45 minutes 6/29/26 at 3:24 p.m. - response time 33 minutes 6/29/26 at 5:57 p.m. - response time 70 minutes 6/30/26 at 6:29 p.m. - response time 67 minutes 7/1/26 at 5:37 p.m. - response time 49 minutes 7/1/26 at 6:38 p.m. - response time 38 minutes 7/1/26 at 8:30 p.m. - response time 45 minutes 7/2/26 at 6:14 p.m. - response time 37 minutes 7/2/26 at 9:10 p.m. - response time 67 minutes 7/3/26 at 11:28 a.m. - response time 77 minutes 7/3/26 at 2:46 p.m. - response time 39 minutes 7/3/26 at 5:38 p.m. - response time 43 minutes 7/4/26 at 12:26 p.m. - response time 66 minutes 7/4/26 at 6:01 p.m. - response time 47 minutes 7/5/26 at 12:35 p.m. - response time 44 minutes 7/5/26 at 6:08 p.m. - response time 56 minutes 7/5/26 at 8:44 p.m. - response time 53 minutes 7/6/26 at 8:08 p.m. - response time 39 minutes 7/6/26 at 6:25 p.m. - response time 51 minutes 7/6/26 at 7:26 p.m. - response time 40 minutes 7/7/26 at 6:09 p.m. - response time 38 minutes 7/7/26 at 7:45 p.m. - response time 74 minutes (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/8/26 at 7:17 a.m. - response time 46 minutes 7/8/26 at 10:17 a.m. - response time 31 minutes 7/8/26 at 6:52 p.m. - response time 53 minutes 7/8/26 at 9:36 p.m. - response time 43 minutes 7/11/26 at 4:29 p.m. - response time 30 minutes 7/11/26 at 5:54 p.m. - response time 54 minutes 7/13/26 at 5:10 p.m. - response time 38 minutes 7/14/26 at 12:15 p.m. - response time 30 minutes 7/14/26 at 7:08 p.m. - response time 60 minutes 7/15/26 at 4:50 p.m. - response time 46 minutes 7/15/26 at 6:06 p.m. - response time 63 minutes 7/16/26 at 4:49 p.m. - response time 32 minutes 7/16/26 at 8:08 p.m. - response time 34 minutes 7/17/26 at 6:22 a.m. - response time 36 minutes 7/17/26 at 12:09 p.m. - response time 50 minutes 7/18/26 at 3:37 p.m. - response time 30 minutes 7/18/26 at 4:07 p.m. - response time 39 minutes 7/19/26 at 3:06 p.m. - response time 42 minutes 7/19/26 at 5:58 p.m. - response time 68 minutes 7/20/26 at 6:07 p.m. - response time 67 minutes 7/21/26 at 4:59 p.m. - response time 92 minutes 7/22/26 at 6:39 p.m. - response time 36 minutes R6's quarterly Minimum Data Set (MDS), dated [DATE], indicated R6 was cognitively intact, required (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff assistance with toileting, had an indwelling catheter and was incontinent of bowel. R6's diagnoses included Crohn's disease (long-term type if inflammatory bowel disease), urinary tract infection, muscle weakness, chronic pain, neuromuscular dysfunction of bladder (lack of bladder control caused by brain, spinal cord or nerve damage), and neurogenic bowel (loss of normal bowel control and function). During an interview on 7/21/26 at 11:09 a.m., R6 stated she had complained several times that the call light was on for up to an hour waiting for staff to assist with incontinent cares. R6 stated she ends up sitting in a bowel movement for extended periods of time resulting in bladder infections. Review of R6's call light logs from 6/21/26- 7/22/26, identified multiple call light response times greater than 30 minutes: 6/22/26 at 6:09 p.m. - response time 115 minutes 6/22/26 at 9:04 p.m. - response time 60 minutes 6/25/26 at 6:23 p.m. - response time 39 minutes 6/25/26 at 7:49 p.m. - response time 71 minutes 6/26/26 at 11:11 a.m. - response time 53 minutes 6/26/26 at 8:46 p.m. - response time 85 minutes 6/27/26 at 9:14 p.m. - response time 31 minutes 6/29/26 at 10:24 a.m. - response time 32 minutes 6/29/26 at 7:39 p.m. - response time 80 minutes 7/1/26 at 4:24 p.m. - response time 38 minutes 7/1/26 5:41 p.m. - response time 44 minutes 7/1/26 at 7:23 p.m. - response time 32 minutes 7/2/26 at 12:33 p.m. - response time 47 minutes 7/2/26 at 6:40 p.m. - response time 62 minutes 7/2/26 at 9:16 p.m. - response time 53 minutes 7/3/26 at 6:44 p.m. - response time 69 minutes (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/6/26 at 8:33 a.m. - response time 42 minutes 7/7/26 at 2:45 p.m. - response time 51 minutes 7/7/26 at 8:07 p.m. - response time 36 minutes 7/8/26 at 6:29 p.m. - response time 47 minutes 7/10/26 at 1:25 p.m. - response time 37 minutes 7/10/26 at 5:37 p.m. - response time 50 minutes 7/11/26 at 6:58 p.m. - response time 37 minutes 7/13/26 at 4:49 p.m. - response time 45 minutes 7/13/26 at 9:32 p.m. - response time 32 minutes 7/14/26 at 5:37 p.m. - response time 61 minutes 7/14/26 at 7:11 p.m. - response time 36 minutes 7/14/26 at 8:47 p.m. - response time 37 minutes 7/15/26 at 3:57 p.m. - response time 136 minutes 7/16/26 at 7:39 p.m. - response time 44 minutes 7/18/26 at 9:15 a.m. - response time 48 minutes 7/19/26 at 8:43 p.m. - response time 47 minutes 7/20/26 at 5:26 p.m. - response time 67 minutes R13's quarterly MDS, dated [DATE], indicated R13 was cognitively intact, diagnoses included hip fracture, traumatic brain injury (TBI), and depression. R13 had lower extremity impairment on both sides, used a wheelchair, required assistance with transfers, and was frequently incontinent. On 7/22/26 at 9:38 a.m., R13 stated she was concerned about long call light times. R13 stated, I'm [AGE] years old. You don't want to be incontinent. Review of R13's call light logs from 6/21/26- 7/22/26, identified multiple call light response times greater than 30 minutes: 6/21/26 at 11:01 a.m. - response time 34 minutes (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/16/26 at 4:29 p.m. &ndash; response time 32 minutes R38's care plan, dated 7/14/26, indicated R38 had an alteration in bladder and bowel elimination, with identified interventions of assist of one with toileting needs. R38's diagnoses included weakness, diabetes, edema and peripheral autonomic neuropathy (damage to peripheral nerves that control involuntary body functions like heart rate, digestion and sweating, common symptom included urinary incontinence. R38's bladder evaluation, dated 7/13/26, indicated R38 had urge incontinence which includes symptoms of strong uncontrolled urgency, frequency of urination, moderate to large amount of urine leakage and enuresis (bedwetting). During an interview on 7/20/26 at 11:41 a.m., R38 stated when the call light was turned on, he waited half an hour or more and has ended up sitting in urine-soaked sheets while waiting for the staff to answer the call light. Review of R38's call light logs from 7/13/26- 7/22/26, identified multiple call light response times greater than 30 minutes: 7/13/26 at 5:06 p.m. &ndash; response time 41 minutes 7/16/26 at 1:06 a.m. &ndash; response time 34 minutes 7/16/26 at 3:40 a.m. - response time 56 minutes 7/16/26 at 2:30 p.m. &ndash; response time 48 minutes 7/16/26 at 5:35 p.m. - response time 89 minutes 7/16/26 at 9:31 p.m. - response time 36 minutes 7/17/26 at 5:04 a.m. &ndash; response time 40 minutes 7/18/26 at 9:25 a.m. - response time 39 minutes During an interview on 7/24/26 at 10:47 a.m., anonymous staff A stated the call boards in the hallways were broken, and staff could only tell when call lights were on was from the nurses' station. Anonymous A stated there were pagers staff wore that alerted them to call lights, but the director of nursing (DON) got rid of those. Anonymous B stated the call light board in the transitional care unit was not working, the call board by the nurses' desk worked periodically, and call board at the end of the hall was broken, faced the floor and had been that way for a while. During an interview on 7/24/26 at 1:25 p.m., registered nurse (RN)-C stated call lights were expected to be answered within 8-10 minutes. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/26 at 1:29 p.m., DON stated when staff were in rooms, the staff would not know what call lights were on, so staff were expected to check boards or the screen when they came out of a resident's room. DON stated the staff were expected to look at the call light boards in the hallways or the screen at the nurses' desk. DON stated there had been occasional issues with the call lights not running due to wi-fi issues. DON stated she was not aware one of the boards was facing the floor. During an interview on 7/24/26 at 2:24 p.m., administrator stated they had completed call light audits on the floor, they had waited at the nurses' station for one to go on and watched the screen to see how long it took for the staff to turn them off. Administrator acknowledged they did not run call light logs to review for long call light times unless a resident had complained. The facility's Call Light policy, updated 5/16/23, indicated call lights must relay the call to a staff member or centralized location where staff were working such as the nurses' station, however, the policy did not address the timing for call lights to be answered.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to maintain the walk-in freezer in a clean and safe condition, as evidenced by a large accumulation of ice on the freezer floor and on stored food boxes, and spilled food items. The facility failed to maintain the dining room resident refrigerator/freezer as evidenced by spilled and undated food items. Additionally, the facility failed to ensure staff completed hand hygiene and wore the appropriate hair coverings in the kitchen. This had the potential to affect all 32 residents residing in the facility. Findings include: During an observation on 07/20/2026 at 9:51 a.m., of the walk-in freezer, a large accumulation of ice was observed on the floor at the end of the shelving on the right side of the freezer. The mound of ice measured approximately 18 inches high with a base measuring approximately 3 feet by 2 feet. A separate chunk of ice measuring approximately 4 inches thick by 6 inches long by 5 inches wide was observed resting on top of a box. Another box stored in the corner had a coating of ice on the top and side. The food items inside the boxes were not observed to be frozen together or covered with ice. During an interview on 07/20/2026 at 9:51 a.m., head cook (HC) stated he had not been at the facility for five days and the ice accumulation was not present the last time he had worked. On 07/20/2026 at 12:50 p.m., the walk-in freezer was observed with regional culinary director (RCD). RCD stated the ice mound should have been taken care of long before this for safety. RCD stated, Someone could come in and slip, and the food could get affected with the ice on the boxes. He further stated it likely had taken approximately three to four months for the ice accumulation to reach its observed size. During an observation on 7/22/26 at 10:30a.m., dietary aide (DA)-A was observed positioned between the stove and metal table mopping the floor. DA-A had a full beard with no cover in place and his hair pulled back in a tail at the back of his neck with no hair cover. The dietary manager (DM) acknowledged DA-A should have a facial hair cover when in the kitchen and directed DA-A to go and apply one. During an interview on 7/22/26 at 10:35 a.m., DA-A reported he usually applied a facial hair cover when entering the kitchen area, but he had forgotten. During a meal service observation on 7/22/26 at 11:19 a.m., nursing assistant (NA)-D entered the kitchen area with her hair in a long ponytail and no hair net. Additionally, NA-D failed to perform hand hygiene upon entering the kitchen area. NA-D went to the walk-in cooler, entered, and returned carrying a glass of milk. During an interview on 7/22/26 at 11:23 a.m., NA-D reported she was retrieving a glass of milk upon a resident's request. NA-D confirmed she had not applied a hairnet, nor performed hand hygiene prior to entering the kitchen area. NA-D reported she should have applied a hairnet, and washed her hands, or requested dietary staff to retrieve the milk, instead of walking into the kitchen area. The DM observed the incident and stated staff walking into the kitchen was not acceptable practice and had been an ongoing issue with unauthorized staff walking into the kitchen. During an observation on 7/22/26 at 12:15 p.m., with the DM of the resident refrigerator/freezer located in the dining room the freezer compartment contained an approximate 1/2-inch layer of ice on the floor of the freezer. The following opened and undated items were in the freezer: 1.5-quart container of Casey's Carmel Cone Sunday ice cream, and a loaf of opened, undated Artesano Hawaiian bread. The door seal contained a granular black substance and food particles, and food particles were noted on the bottom and shelves to the freezer. The refrigerator section contained the following opened and undated items: an opened carton of Top the Tator sour cream dip, four plastic containers of pickles, a paper Culvers bag with a sandwich and fries. The seal of the refrigerator door had a black granular substance in the seal and hinge area of the door. The door frame, shelves, and bottom of the refrigerator contained spilled food (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	particles. During an interview on 7/22/26 at 11:29 a.m., DM stated the cleaning schedule indicated the refrigerator had last been cleaned on 7/21/26, but it had not been cleaned according to DM's expectations. DM stated food placed in the resident refrigerator was expected to be written on the log posted on the front of the refrigerator, and was to include the date, placed in the refrigerator, name, date the item was opened. The facility's Refrigerators and Freezers policy, revised 12/2014, indicated supervisors would inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs, and manufacturer maintenance guidelines would be scheduled and followed. The facility's Food Brought by Family/Visitors policy, revised October 2017, indicated food brought by family or visitors and left for the resident to consume later was to be labeled and stored in a manner distinguishable from facility-prepared food. Non-perishable foods must be stored in re-sealable containers with tight-fitting lids. Perishable foods must be stored in re-sealable containers with tight fitting lids in a refrigerator. Containers must be labeled with the resident's name, the item, and the use by date. Nursing staff will discard perishable foods on or before the use by date. The nursing and/food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger.		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) who was also the director of nursing (DON) had appropriate oversight of the infection control (IC) program that included employee surveillance of all employees. This had the potential to affect all 32 residents. Findings include: Review of facility infection control surveillance documents identified the infection preventionist (IP) managed resident illness surveillance, which was included in the infection control surveillance documentation. However, no employee surveillance was included in the infection control surveillance documentation. During an interview on 7/22/26 at 10:23 a.m., the director of nursing/infection preventionist (DON/IP) stated she had nothing to do with tracking or managing employee illness. DON/IP stated employee illness was tracked and managed by the human resources (HR)/scheduling coordinator. The DON/IP stated when an employee called in sick, the scheduling coordinator received the call and tracked their illness by asking the appropriate questions per policy and procedure. The DON/IP reported employee illnesses (call-ins) were discussed during the morning meeting which allowed nursing to add in any suspected correlation between employee illness and resident illness. The DON/IP identified she did not maintain documentation of the morning meetings. During an interview on 7/22/26 at 2:32 p.m., the staffing coordinator (SC) stated when a staff person called-in ill, they were to call both the facility and the staffing phone to notify the department head which staff were calling in and administration. SC reported she primarily dealt with nursing staff and when she received a call-in, she attempted to find a replacement. SC identified the forms filled out for staff call-ins were kept in the scheduling binder in her office. SC stated she was not responsible for activity, or culinary staff and managers of those departments managed their own staff call-ins. Review of the forms filled out for staff call-ins indicated the following: -Nursing assistant (NA)-E had called-in on 4/22/26 with reported symptoms of diarrhea beginning 4/20/26 through 4/22/26. NA-E returned to work on 4/25/26, but there was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure NA-E was safe to return to work, or if NA-E had been prohibited from work for an appropriate amount of time. NA-E's time punches were requested but not provided. -NA-C left her shift on 4/5/26 with complaints of nausea and returned to work on 4/19/26. There was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure staff were safe to return to work, or if NA-C had been prohibited from work for an appropriate amount of time. NA-C's time punches were requested but not provided. -Cook-A called-in with vomiting on 5/3/26, reported symptoms resolved on 5/4/26 and returned to her shift in dietary on 5/5/26. There was no indication if the facility had followed infection control standards for criteria in-order to ensure cook-A was safe to return to work, or if cook-A had been prohibited from work for an appropriate amount of time. Cook-A's time punches identified she was off 5/3/26-5/4/26 and returned on 5/5/26. -Dietary Aid (DA)-A called-in on 6/30/26 with complaints of nausea, no additional data was provided and review of DA-A's timecard identified he returned to his shift in the dietary department the next day, on 7/1/26. There was no indication of resolution of symptoms, if the facility had followed infection control standards for criteria in-order to ensure DA-A was safe to return to work, or if DA-A had been prohibited from work for an appropriate amount of time. During an interview on 7/22/26 at 4:15 p.m., with the dietary manager (DM) reviewed timecards for the two dietary staff that had call-in with GI symptoms and identified he had followed the MN policy posted in the kitchen which listed an employee must wait 24 hours from their last symptom before returning to work. DM stated cook-A had started her shift on (continued on next page)		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/5/26 at 5:00 a.m. which was not within the required time from her last symptom. DM also reported he had been out on leave from 6/15/26 through 7/21/26 and did not know who was overseeing the monitoring of illness for dietary department when he was out on leave, but he assumed someone had. The Infection Preventionist job description identified the IP was responsible to evaluate practice in culinary, laundry, housekeeping, maintenance, and nursing departments to ensure consistency with recommended infection control standards. The IP conducts ongoing infection surveillance, compiles and analyzes data, and prepares reports for presentation to the Infection Prevention and Control Oversight Committee. The facility's Infection Prevention and Control Program policy, dated 4/26/26, indicated it was comprehensive and addressed detection, prevention, and control of infections among residents and personnel. The infection prevention and control program is coordinated and overseen by the IP. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Surveillance tools are used for recognizing the occurrence of infection, recording their number and frequency, detecting outbreaks, monitoring employee infections, and detecting unusual pathogens with infection control implications. The major elements of the program included coordination/oversight, surveillance, outbreak management, prevention of infection, and employee health.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed for all medications kept at bedside for 3 of 3 residents (R1, R13, R30) observed with medications at their bedside. Findings include: R1's significant change Minimum Data Set (MDS), dated [DATE], indicated R1 was cognitively intact and required assistance with activities of daily living. R1's diagnoses included respiratory failure, chronic pain, anxiety, and asthma. R1's Order Summary Report, printed 7/27/26, indicated R1 had an order for Ventolin HFA Inhalation Aerosol Solution (short acting inhaler, relaxes tight muscles in the airway) 108 micrograms/actuation (Mcg/Act) 2 puffs inhale every four hours as needed for shortness of breath. The summary report also indicated R1 had an order dated 1/28/26 for okay to self-administer inhalers at bedside after set-up pending nursing assessment of self-administration. R1's Self Administration of Medication (SAM) Evaluation, dated 6/23/26, indicated per staff resident no longer self-administered any medications or creams. She used to but no longer does self-administer nor does she request to do so. During an observation on 7/22/26 at 3:02 p.m., R1's Ventolin inhaler was observed on the overbed table next to R1's bed, within reach of R1. During an observation on 7/23/26 at 8:29 a.m., R1's inhaler was observed on top of overbed table next to R1's bed. During an interview on 7/23/2026 1:47 p.m., registered nurse (RN)-A stated R1 had an inhaler but it was no longer kept at her bedside. RN-A stated the nurse manager or the director of nursing (DON) completed the self-administration of medications assessments. During an interview on 7/24/26 at 1:04 p.m., RN-C stated R1 needed to demonstrate how to use the inhaler correctly and verbalize when to use the inhaler. RN-C reviewed R1's assessment and verified RN-C's name was on the assessment as having completed the assessment for R1. R13's quarterly MDS, dated [DATE], indicated R13 was cognitively intact, and diagnoses included traumatic brain injury (TBI), diabetes, and asthma. On 7/20/26 at 9:38 a.m., a medication cup with 9 tablets/capsules was observed on R13's bedside table. R13 stated she had just woken up and found the medication left at her bedside. During an observation on 7/21/26 at 9:34 a.m., a medication cup with 8.5 tablets/capsules was observed on R13's bedside table. R13 was not in the room at the time. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/26 at 9:25 a.m., a medication cup with tablets/capsules was observed on R13's bedside table. R13 stated medications had been left at bedside for at least 6 months. R13's Order Summary Report, dated 7/8/26, indicated R13 had an order dated 5/11/26 for may self-administer medication after nursing setup. R13's SAM Evaluation, dated 5/13/26, indicated R13 was safe to self-administer medication after nursing set up, and inhalers and lozenges kept at bedside. R13's SAM Evaluation, dated 5/25/26, indicated R13 was able to keep inhaler and lozenges at bedside and self-administer inhalers as ordered, and was able to self-apply lotions and ointments after nursing set up. The evaluation further indicated, All other medications will be set up and administered by nursing as there have been multiple events of resident forgetting to take medications after they area [sic] set up and left with resident, resulting in missed doses. However, R13's electronic health record (EHR) lacked evidence the 5/25/26 SAM evaluation results had been communicated to the provider. Additionally, the EHR lacked evidence R13's orders and care plan had been updated to reflect the updated evaluation findings. R13's Medication Administration Record (MAR), dated July 2026, indicated ok to leave tizanidine and Lyrica at bedside, with a start date of 7/14/26. However, no other medications were ordered as okay to leave at bedside. During an interview on 7/22/26 at 9:44 a.m., RN-B stated he had set up R13's medications that day. RN-B stated he left the medications at the bedside for R13 as allowed per provider orders. R30's quarterly MDS, dated [DATE], indicated R30 was cognitively intact and diagnoses included hepatic encephalopathy (a worsening of brain function when a damaged liver can no longer remove toxic substances from the blood), heart failure, and diabetes. R30's SAM Evaluation, dated 4/21/26, indicated R30 was not reliably safe to self-administer medications. Additionally, the evaluation did not indicate that R30 was able to keep any medications at bedside. On 7/21/26 at 10:38 a.m., fluticasone propionate nasal spray was observed at R30's bedside. R30 stated she normally self-administered the nasal spray. R30's MAR, dated July 2026, indicated R30 had an order for Fluticasone Propionate nasal suspension 50 mcg/act 2 spray in each nostril two times a day for allergic rhinitis. No orders for self-administration or medications at bedside were indicated on the MAR. During an interview on 7/24/26 at 11:12 a.m., director of nursing (DON) verified R13's SAM evaluation indicated she was not safe to self-administer medications. The facility's Self-Administration of Medications policy, dated 2/2024, indicated the interdisciplinary (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide reasonable accommodation of needs and preferences for 1 of 1 resident (R28) reviewed for environmental scents. Findings include: R28's quarterly Minimum Data Set (MDS), dated [DATE], indicated R28 was cognitively intact, and diagnoses included diabetes, heart failure, asthma, and allergies. R28's care plan, last revised 5/21/26, indicated R28 had multiple allergies and intolerances, many allergies to different scents, and required assist of one with bathing. During an interview on 7/20/26 at 2:30 p.m., R28 stated she does not participate in activities due to allergies and used an N-95 mask to provide scent blockage. R28 stated because of the chemicals and fragrances used in the shower room, she did not get her scheduled shower. R28 stated she has gone up to three weeks a couple of times without showers. R28 stated that one time staff had her use the shower room before any other residents and she showered without any issues. During an interview on 7/23/26 at 2:12 p.m., nursing assistant (NA)-D stated R28 was very sensitive to smells and wore a mask a lot. During an interview on 7/23/26 at 3:49 p.m., NA-E stated R28 required supervision with showers, and R28 was very sensitive to scents or odors. During an interview on 7/24/26 at 10:31 a.m., environmental service (ES) stated the facility took residents' sensitivity to chemical smells seriously. ES stated R28 had a sign on her door that it is a scent-free room due to R28's allergies, and staff followed the posted restrictions. ES stated the employee handbook instructed staff to not wear strong perfume or extra aroma items because it showed respect for the residents. During an interview on 7/24/26 at 2:46 p.m., registered nurse manager (RN)-C stated the facility made arrangements one time for R28 to be offered the first shower of the day. RN-C stated R28 has not requested the first shower of the day since. The facility's Employee Handbook 2026 indicated scents must be limited and barely perceptible, in recognition of resident sensitivities and allergies.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident remained free from physical restraints not required to treat a medical symptom when the facility incorporated the use of law enforcement handcuffs into resident's care plan for 1 of 1 resident (R45) reviewed for restraints. Findings include: R45's admission record, printed 7/24/26, indicated R45 admitted to the facility on [DATE], and diagnoses included abdominal aortic aneurysm without rupture and diabetes. R45's care plan, initiated 7/21/26, indicated a physical restraint was deemed necessary by county policy due to R45's criminal history. The care plan indicated corrections staff would remain in R45's room or observe R45 at all times. The care plan further indicated R45 would be handcuffed if security left the room, and security staff would place and remove handcuffs for the resident. However, the care plan also indicated staff would place and remove handcuffs PRN (as needed). R45's Informed Consent for Use of Physical Restraints, signed 7/21/26, listed the type of restraint as handcuffs when not in vision of security guard due to the need for 24-hour supervision related to admitting to hospital and SNF from jail. R45's Order Summary Report, dated 7/24/26, indicated an order OK to apply handcuffs to resident as needed for safety every shift, with a start date of 7/21/26. However, the order did not identify a medical symptom that warranted the use of the restraint. During an interview on 7/24/26 at 10:47 a.m., anonymous staff A stated there was an inmate in the facility. Staff had been instructed to provide a shower for R45 with two staff present, the guard was to remain in the room and R45 was to be handcuffed to the shower chair. However, the correctional officer left the shower area, leaving the two nursing assistants alone with the resident while he was not handcuffed. During an interview on 7/24/26 at 12:49 p.m., the correctional officer stated he had been informed by the facility that handcuffing the resident was not necessary if the officer briefly stepped away from the room. During an interview on 7/24/26 at 1:49 p.m., director of nursing (DON) stated the resident was to be handcuffed to the bed whenever the guard left the room, staff were to complete skin assessments related to the handcuffs, and the guard would leave the key with nursing staff in case of an emergency. DON stated only the guards applied or removed the handcuffs, and facility staff were not to be in control of the restraint. During an interview on 7/24/26 at 2:34 p.m., administrator stated that R45 was handcuffed whenever the guard stepped away from the room. The guard was required to inform the staff they were stepping away and handed the keys to the nurse. Administrator stated the facility staff were allowed to remove the handcuffs in case of emergency. Facility policy regarding physical restraints was requested, however, none was provided.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were free from unnecessary psychotropic medications, including failure to ensure as needed (PRN) psychotropic medications had appropriate stop dates for 1 of 5 residents (R20) reviewed for unnecessary medications. Findings include: R20's admission Minimum Data Set (MDS), dated [DATE], indicated R20 was cognitively intact and required assistance from staff with activities of daily living (ADLs). R20's diagnoses included emphysema (lung disease), major depression, panic disorder, post-traumatic stress disorder, and anxiety. R20's physician orders, dated 7/8/26, identified R20 had orders for olanzapine (an antipsychotic) 5 milligrams (mg) by mouth every twelve hours PRN for anxiety initiated 7/2/26, trazodone (an antidepressant) 25mg every twenty-four hours PRN for insomnia initiated 7/2/26, and hydroxyzine (a sedating antihistamine/psychotropic) 50 mg every six hours PRN for anxiety initiated 7/2/26. However, R20's olanzapine, trazodone and hydroxyzine orders did not include a stop date, specific duration, or documented prescriber rationale for extending the PRN psychotropic medication beyond 14 days, as required. During an interview on 7/24/26 at 1:04 p.m., registered nurse (RN)-C stated PRN psychotropic medications required an end dated of at least 14 days, the provider could write the order for longer but had to provide a rational. RN-C reviewed R20's physician orders and verified end dates were not indicated on the orders. During an interview on 7/24/26 at 1:06 p.m., director of nursing (DON) stated when PRN psychotropic medication orders were received, the expectation was for the nurses to contact the provider and obtain an end date as required. DON reviewed R20's medications and confirmed there were no end dates for R20's psychotropic medications. The facility's Psychotropic Medication Use policy, revised 5/2025, indicated PRN orders for psychotropic medications would be limited to 14 days unless the physician identified the rational to extend the medication beyond 14 days.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident's (R43) discontinued controlled narcotic medication was not stored with in-use medications in 1 of 3 medication carts. Findings include: During an observation on 7/21/26 at 10:56 a.m., of the South Hall medication cart narcotic cabinet with registered nurse (RN)-A identified three medications identified for R43 who passed away on 7/17/26. R43's-controlled medications remained in the narcotic cabinet with current in use medications. The medications included: Lorazepam (Ativan a controlled medication used for anxiety), 1 blister package card containing 30 0.5 milligram (mg) tablets. Lorazepam liquid in a 25-milliliter bottle with orders 0.25ml by mouth (PO) every (Q) 4 hours (H) scheduled and 0.25ml Q2H as needed (PRN). 24.75 ml remained in the bottle. Hydromorphone (Dilaudid a prescription opioid medication) liquid with orders to administer 1 ml Q4H scheduled, and Q1H PRN. 109ml remained in the bottle. During an interview on 7/21/26 at 11:00 a.m., RN-A identified controlled medications remained stored in the locked narcotic drawer on medication carts until 2 licensed nurses had time to destroy and log them. RN-A reported she was unaware that discontinued controlled medication were not to be stored with in-use medications. During an interview on 7/21/26 at 11:16 a.m., director of nursing (DON) confirmed R34 had passed away in the facility on 7/17/26 and her medications should have been counted, documented in the narcotic log, and removed from the narcotic cabinet on the medication cart, and stored in a secure, double locked, area until 2 licensed nurses were able to destroy them. A policy on management of controlled discontinued medications was requested but not provided.		