Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL281123442M
Compliance #: HL281126548C

Date Concluded: August 4, 2025

Name, Address, and County of Licensee Investigated:
The Gardens of Winsted AL
300 Fairlawn Avenue West
Winsted, MN, 55395
Mcleod County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected resident #1 and resident #2 when staff failed to provide sufficient supervision. As a result, there was unwanted resident-to-resident sexual contact. In addition, because of the incident, the facility failed to allow resident #1 to continue to attend facility activities.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Resident #1 was found in resident #2's room with resident #2's hand inside the front of resident #1's pants. At the time of the incident, staff were providing cares and services according to both residents' plan of care. Resident #2 had no known history of sexually inappropriate behaviors. In addition, following the incident resident #1 continued to attend scheduled activities with other residents with continuous staff supervision. During an onsite observation, resident #1 was observed seated directly next to unlicensed staff playing bingo.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of both residents' records, facility internal investigation, facility incident report, law enforcement report, and related facility policy and procedures. Also, the investigator observed the facility, observed resident #1 and resident #2, and staff interactions with residents.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included dementia. Resident #1'2 service plan included assistance with reassurance checks at scheduled times during the day which included 6:00 a.m., 9:00 a.m., 12:00 p.m. and 2:00 p.m. and cues of redirection as needed. Resident #1's assessment indicated the resident walked independently, was oriented to person, forgetful, confused, and wandered. Resident #1 had complete hearing loss on the right side, moderate hearing loss on the left, and had visual loss. Resident #1's vulnerability assessment indicated goals for a support system included meeting new people and to take part in social activities to enhance quality of life. Resident #1 did not exhibit inappropriate sexual behaviors.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia. Resident #2's service plan included assistance with reassurance checks at scheduled times during the day which included 6:00 a.m., 8:00 a.m., 10:00 a.m. 12:00 p.m. and 2:00 p.m., cues of redirection as needed. Resident #2's assessment indicated the resident walked independently, was oriented to person, forgetful, confused, wandered, and had impaired decision making. Resident #2's vulnerability assessment indicated goals for a support system included meeting new people and to take part in social activities to enhance quality of life. Resident #2 did not exhibit inappropriate sexual behaviors.

During observation, resident #1 and resident #2's room placement was located on opposite sides of the facility. Resident #2's shared room consisted of hung linen curtain entrances to the left and ride side of the room.

The facility internal investigation indicated one day at around 1:15 p.m., both residents were attending activities. About fifteen minutes later, during the activity an unlicensed entered resident #2's room to assist his roommate. The unlicensed staff heard a female voice say "No". At that time, the unlicensed staff observed resident #2's hand inside resident #2's pants. Resident #2's hand was between resident #1's thighs near resident #1' peri-area. The unlicensed staff separated both residents to their room on opposite sides of the building. Every 15-minute checks were implements for both residents. Both residents had skin checks with no noted redness, abrasions, or bruising on their body.

The facility reassurance checks audits indicated after the incident facility staff monitored resident #1 and resident #2 every 15 minutes, then adjusted to every 30 minutes, and after that every one hour. The internal investigation timeline indicated both residents returned to staff reassurance check monitoring according to their service agreement.

During an interview, unlicensed personnel stated resident #1 and resident #2 both walked independently. Both residents were watching a singing group perform on resident #2's side of the facility. The unlicensed personnel stated she was present, had cleaned up the area after lunch, and was providing cares to other residents going in and out of rooms. The unlicensed personnel stated she entered resident #2's shared room to assist resident #2's roommate. Unlicensed personnel stated In the room she heard voices coming from resident #2's side of the room. The unlicensed personnel stated she heard a female say "no" "stop." The unlicensed personnel entered resident #2's side of the room and observed resident #2's hand down the inside front of resident #1's pants. The unlicensed personnel immediately intervened, was able to redirect resident #2 away from resident #1, and separated the two residents. The unlicensed personnel stated she walked resident #1 back to her room on the other side of the facility. Unlicensed staff stated she checked resident #1's skin and said resident #1 did not have any visible injury, scratches, or marks. The unlicensed personnel stated she did not see resident #1 and resident #2 leave the singing group activity and walk back to resident #2's room.

During an interview, a nurse stated after the incident, resident #1 and resident #2's skin was checked by unlicensed staff and was also assessed by licensed nurses. Nothing abnormal was observed. Both resident #1 and resident #2 had a BIMS (Brief Interview for Mental Status) conducted, which indicated both residents were severely cognitively impaired. The nurse stated the behavior was out of character for resident #2, and they had not witnessed that type of behavior from resident #2 before. The nurse stated since the incident, resident #1 was not prevented from attending facility activities.

During an interview, another nurse stated after the incident resident #2 was assessed by facility licensed nurses and evaluated by his provider. There had been no prior incidents involving resident #2's inappropriate sexual behaviors, and there had been no further incidents of this nature. Both resident #1 and resident #2 did not recall the incident when licensed nurses assessed and spoke to them. The nurse stated the facility acted and implemented interventions to have staff always present to supervise resident #1 when resident #1 was on resident #2's side of the facility for activities.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Attempted.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff immediately separated both residents, skin checks and vulnerability assessments were conducted, Resident #1 and Resident #2 providers were updated, facility educated staff to ensure continuous supervision when residents are together for activities from either side of the facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28112	A. BUILDING: _____ B. WING _____	C 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED AL	300 FAIRLAWN AVENUE WEST WINSTED, MN 55395

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On July 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL281126548C/#HL281123442M. No correction orders are issued.	0 000		