Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 6, 2026

Administrator
Lake Winona Manor
865 MANKATO AVENUE
WINONA, MN 55987

RE: CCN: 245240
Cycle Start Date: March 5, 2026

Dear Administrator:

On April 20, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Winona Manor	**865 MANKATO AVENUE , WINONA, Minnesota, 55987**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/2/26 to 3/5/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		03/26/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H52404923C (1064647) and H52404922C (2617715). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.	21565	On 3/4/26 staff removed the medication from R8’s room. The policy for Self-Administration was reviewed and revised by 3/23/26. An audit of all resident rooms was completed by a member of the nursing team by 3/24/26 to locate any other unordered medications in all resident rooms. All defects were reported to the nurse for prompt investigation and follow-up. Education to all nursing staff will provided by 3/31/26 . An audit of five resident rooms, will occur weekly x 5. All results will be shared with the QA&I Committee for further action.	03/24/2026

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21565	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed for 1 of 1 resident (R8) reviewed for self-administration of medication. Findings include: R8's Quarterly Minimum Dat Set (MDS) assessment, dated 2/10/26 indicated R8 was cognitively intact. Further, R8 was independent with eating and basic personal hygiene and dependent on facility staff for mobility and transfers. R8's record lacked an assessment to self-administer medications. During observation and interview on 3/2/26 at 7:01 p.m., a Voltaren Gel (pain relief) tube was observed sitting in a basket on R8's tray table. R8 stated he used the Voltaren Gel on both his knees when he had pain. R8 stated he would use the gel throughout the day and is unsure how many times per day. R8 lacked an order for Voltaren Gel. During observation and interview on 3/4/26 at 8:54 a.m., licensed practical nurse (LPN)-A was observed administering R8's morning medications. The Voltaren Gel remained in the basket on R8's tray table. R8 again stated, he uses the Voltaren Gel on his knees when they are causing him pain. LPN-A completed R8's medication administration and left the room. During an interview on 3/4/26 at 9:01 a.m., LPN-A stated she was unsure if R8 had an order for the Voltaren Gel and if he had been assessed to administer the medication himself. Upon review, LPN-A confirmed R8 had neither an order to use the Voltaren Gel nor an assessment to be able to self-administer the medication. LPN-A stated it is important to have an order for the Voltaren Gel, so the provider team knows all the medications R8 was taking. LPN-A indicated it is important R8 have an assessment to administer his own medication to make sure he is capable to administer the medication and that he can administer the medication as directed by the order. During an interview on 3/4/26 at 11:15 a.m., nurse manager (NM)-A stated medications such as Voltaren Gel should have a provider order. Further, if the resident would like to administer the medication themself, they	21565		

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21565	Continued from page 3 would need to be assessed to make sure they can administer the medication as directed by the medication order. NM-A stated if a nurse found a medication in a room, she would expect the nurse to follow up to make sure there was an order for the medication, and the resident had been assessed to have the medication in his room. NM-A stated it is important to have an order for all medications and residents are assessed to give the medication, this will ensure the providers are aware of all the medications a resident is taking, and to make sure the resident can safely administer the medication as ordered. During an interview on 3/4/26 at 2:19 p.m., the administrator/director of nursing stated all medications, even pain gels such as Voltaren Gel, need to have a prescriber order to administer. Further, if a resident would like to administer the medication, they would need to be appropriately assessed to ensure the resident can administer the medication as prescribed. The administrator/director of nursing stated if staff found medication in a resident room, she would expect them to verify the medication was ordered and remove the medication if it was not. Additionally, if the medication was ordered she would expect staff to verify if the appropriate self-administration assessment had been completed, removing the medication if it had not. During observation on 3/5/26 at 11:52 a.m., the Voltaren Gel remained sitting in a basket on R8's tray table. Additionally, an order for the Voltaren Gel had not been completed, and assessment for self-administration had not been completed. A facility policy titled Medication Administration dated 12/24, a resident may not be permitted to administer or retain any medication in his/her room unless it is so ordered by the provider and appropriate assessment is completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21565		
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4	21800	On 3/9/26 all Resident Rights Posters were updated. The policy for Resident Rights was reviewed and revised by 3/17/26. Education was provided to administrative staff	03/24/2026

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21800	Continued from page 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 64 residents currently residing in the facility as well as all staff and visitors. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21800	Continued from page 4 regarding posting of resident rights and where to obtain newly released state and federal language online by 3/24/26. Monitoring for updates has been added to the Quarterly QA&I Committee agenda for ongoing monitoring and further action.	

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May 6, 2026

Administrator
Lake Winona Manor
865 MANKATO AVENUE
WINONA, MN 55987

Re: Reinspection Results
Event ID: 1E3F55-H2

Dear Administrator:

On April 20, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 5, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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E0000	Initial Comments On 3/2/26 to 3/5/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/26/2026
F0000	INITIAL COMMENTS On 3/2/26 to 3/5/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52404922C (2617715) and H52404923C (1064647). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		03/26/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications	F0554	On 3/4/26 staff removed the medication from R8's room. The policy for Self-Administration was reviewed and revised by 3/23/26. An audit of all resident rooms was completed by a member of the nursing team by 3/24/26 to locate any other unordered medications in all resident	03/24/2026

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 reverse for further 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.

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F0554 SS = D	Continued from page 1 if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed for 1 of 1 resident (R8) reviewed for self-administration of medication. Findings include: R8's Quarterly Minimum Dat Set (MDS) assessment, dated 2/10/26 indicated R8 was cognitively intact. Further, R8 was independent with eating and basic personal hygiene and dependent on facility staff for mobility and transfers. R8's record lacked an assessment to self-administer medications. During observation and interview on 3/2/26 at 7:01 p.m., a Voltaren Gel (pain relief) tube was observed sitting in a basket on R8's tray table. R8 stated he used the Voltaren Gel on both his knees when he had pain. R8 stated he would use the gel throughout the day and is unsure how many times per day. R8 lacked an order for Voltaren Gel. During observation and interview on 3/4/26 at 8:54 a.m., licensed practical nurse (LPN)-A was observed administering R8's morning medications. The Voltaren Gel remained in the basket on R8's tray table. R8 again stated, he uses the Voltaren Gel on his knees when they are causing him pain. LPN-A completed R8's medication administration and left the room. During an interview on 3/4/26 at 9:01 a.m., LPN-A stated she was unsure if R8 had an order for the Voltaren Gel and if he had been assessed to administer the medication himself. Upon review, LPN-A confirmed R8 had neither an order to use the Voltaren Gel nor an assessment to be able to self-administer the medication. LPN-A stated it is important to have an order for the Voltaren Gel, so the provider team knows all the medications R8 was taking. LPN-A indicated it is important R8 have an assessment to administer his own medication to make sure he is capable to administer the medication and that he can administer the medication as directed by the order.	F0554	Continued from page 1 rooms. All defects were reported to the nurse for prompt investigation and follow-up. Education to all nursing staff will provided by 3/31/26 . An audit of five resident rooms, will occur weekly x 5. All results will be shared with the QA&I Committee for further action.	

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F0554 SS = D	Continued from page 2 During an interview on 3/4/26 at 11:15 a.m., nurse manager (NM)-A stated medications such as Voltaren Gel should have a provider order. Further, if the resident would like to administer the medication themself, they would need to be assessed to make sure they can administer the medication as directed by the medication order. NM-A stated if a nurse found a medication in a room, she would expect the nurse to follow up to make sure there was an order for the medication, and the resident had been assessed to have the medication in his room. NM-A stated it is important to have an order for all medications and residents are assessed to give the medication, this will ensure the providers are aware of all the medications a resident is taking, and to make sure the resident can safely administer the medication as ordered. During an interview on 3/4/26 at 2:19 p.m., the administrator/director of nursing stated all medications, even pain gels such as Voltaren Gel, need to have a prescriber order to administer. Further, if a resident would like to administer the medication, they would need to be appropriately assessed to ensure the resident can administer the medication as prescribed. The administrator/director of nursing stated if staff found medication in a resident room, she would expect them to verify the medication was ordered and remove the medication if it was not. Additionally, if the medication was ordered she would expect staff to verify if the appropriate self-administration assessment had been completed, removing the medication if it had not. During observation on 3/5/26 at 11:52 a.m., the Voltaren Gel remained sitting in a basket on R8's tray table. Additionally, an order for the Voltaren Gel had not been completed, and assessment for self-administration had not been completed. A facility policy titled Medication Administration dated 12/24, a resident may not be permitted to administer or retain any medication in his/her room unless it is so ordered by the provider and appropriate assessment is completed.	F0554		
F0572 SS = C	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.	F0572	On 3/9/26 all Resident Rights Posters were updated. The policy for Resident Rights was reviewed and revised by 3/17/26. Education was provided to administrative staff regarding posting of resident rights and where to obtain newly released state and federal language online by 3/24/26. Monitoring for updates has been added to the Quarterly QA&I Committee agenda for ongoing monitoring and further action.	03/24/2026

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F0572 SS = C	Continued from page 3 §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 64 residents currently residing in the facility as well as all staff and visitors. Findings include: During observation on 3/3/26, at 11:45 a.m. the Resident Bill of Rights poster, dated 1/2019, was observed near the entrance to the building. A second Combined Bill of Rights poster, dated 1/2016, was posted next to the elevator going to the second floor. During interview 3/4/26, at 3:29 p.m., administrator stated she was unaware of the newly released Resident Bill of Rights poster, effective 1/1/26, which was to replace any previous posters. The facility policy, effective 8/1/21, titled Resident Rights, was reviewed, and identified residents had the right to be informed by the facility of rights granted within the Bill of Rights, which was to also include the recourse residents had if rights were violated. The policy identified the Bill of Rights were to be posted in a conspicuous location within the facility.	F0572		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F0577	On 3/5/26 the last annual Life Safety Code results were posted on all areas where survey results are made available and accessible to the public. On 3/17/26 a policy was developed and released to address the	03/24/2026

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F0577 SS = C	Continued from page 4 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure facility survey results were posted in an accessible location for residents, staff and visitors. This had the potential to affect all 64 residents residing in the facility as well as staff and visitors. Findings include: On 3/3/26, at 11:45 a.m. a review of the survey results binder located near the elevator was completed. Although the previous recertification survey of 12/5/24 was found within the survey binder, the Life Safety Code (LSC) 2567, completed 12/4/25, was not located in the binder. During interview on 3/3/26, at 1:12 p.m. the administrator stated she was unaware the LSC 2567 survey results were not in the survey binder.	F0577	Continued from page 4 posting and accessibility of survey results. Administrative staff were educated on the policy 3/24/26 and will monitor survey result materials for compliance monthly x 6. All results will be reviewed by the QA&I Committee for further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Winona Manor	865 MANKATO AVENUE , WINONA, Minnesota, 55987

(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) COMPLETION DATE
F0577 SS = C	Continued from page 5 Administrator stated it was important for the survey results to be available for review by residents, staff and visitors for so they may be aware of the previous survey results. A request was made for the facility policy for posting of survey results, however, a policy was unavailable.	F0577		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2026

Administrator
Lake Winona Manor
865 MANKATO AVENUE
WINONA, MN 55987

RE: CCN:245240
Cycle Start Date: March 5, 2026

Dear Administrator:

On Cycle March 5, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 5, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social

Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 5, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2026

Administrator
Lake Winona Manor
865 MANKATO AVENUE
WINONA, MN 55987

Re: State Nursing Home Licensing Orders

Event ID: 1E3F55-H1

Dear Administrator:

The above facility survey was completed on March 5, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion, and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Winona Manor	865 MANKATO AVENUE , WINONA, Minnesota, 55987

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E0000	Initial Comments On 3/2/26 to 3/5/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/26/2026
F0000	INITIAL COMMENTS On 3/2/26 to 3/5/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52404922C (2617715) and H52404923C (1064647). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		03/26/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications	F0554	On 3/4/26 staff removed the medication from R8's room. The policy for Self-Administration was reviewed and revised by 3/23/26. An audit of all resident rooms was completed by a member of the nursing team by 3/24/26 to locate any other unordered medications in all resident	03/24/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

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F0554 SS = D	Continued from page 1 if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed for 1 of 1 resident (R8) reviewed for self-administration of medication. Findings include: R8's Quarterly Minimum Dat Set (MDS) assessment, dated 2/10/26 indicated R8 was cognitively intact. Further, R8 was independent with eating and basic personal hygiene and dependent on facility staff for mobility and transfers. R8's record lacked an assessment to self-administer medications. During observation and interview on 3/2/26 at 7:01 p.m., a Voltaren Gel (pain relief) tube was observed sitting in a basket on R8's tray table. R8 stated he used the Voltaren Gel on both his knees when he had pain. R8 stated he would use the gel throughout the day and is unsure how many times per day. R8 lacked an order for Voltaren Gel. During observation and interview on 3/4/26 at 8:54 a.m., licensed practical nurse (LPN)-A was observed administering R8's morning medications. The Voltaren Gel remained in the basket on R8's tray table. R8 again stated, he uses the Voltaren Gel on his knees when they are causing him pain. LPN-A completed R8's medication administration and left the room. During an interview on 3/4/26 at 9:01 a.m., LPN-A stated she was unsure if R8 had an order for the Voltaren Gel and if he had been assessed to administer the medication himself. Upon review, LPN-A confirmed R8 had neither an order to use the Voltaren Gel nor an assessment to be able to self-administer the medication. LPN-A stated it is important to have an order for the Voltaren Gel, so the provider team knows all the medications R8 was taking. LPN-A indicated it is important R8 have an assessment to administer his own medication to make sure he is capable to administer the medication and that he can administer the medication as directed by the order.	F0554	Continued from page 1 rooms. All defects were reported to the nurse for prompt investigation and follow-up. Education to all nursing staff will provided by 3/31/26 . An audit of five resident rooms, will occur weekly x 5. All results will be shared with the QA&I Committee for further action.	

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F0554 SS = D	Continued from page 2 During an interview on 3/4/26 at 11:15 a.m., nurse manager (NM)-A stated medications such as Voltaren Gel should have a provider order. Further, if the resident would like to administer the medication themself, they would need to be assessed to make sure they can administer the medication as directed by the medication order. NM-A stated if a nurse found a medication in a room, she would expect the nurse to follow up to make sure there was an order for the medication, and the resident had been assessed to have the medication in his room. NM-A stated it is important to have an order for all medications and residents are assessed to give the medication, this will ensure the providers are aware of all the medications a resident is taking, and to make sure the resident can safely administer the medication as ordered. During an interview on 3/4/26 at 2:19 p.m., the administrator/director of nursing stated all medications, even pain gels such as Voltaren Gel, need to have a prescriber order to administer. Further, if a resident would like to administer the medication, they would need to be appropriately assessed to ensure the resident can administer the medication as prescribed. The administrator/director of nursing stated if staff found medication in a resident room, she would expect them to verify the medication was ordered and remove the medication if it was not. Additionally, if the medication was ordered she would expect staff to verify if the appropriate self-administration assessment had been completed, removing the medication if it had not. During observation on 3/5/26 at 11:52 a.m., the Voltaren Gel remained sitting in a basket on R8's tray table. Additionally, an order for the Voltaren Gel had not been completed, and assessment for self-administration had not been completed. A facility policy titled Medication Administration dated 12/24, a resident may not be permitted to administer or retain any medication in his/her room unless it is so ordered by the provider and appropriate assessment is completed.	F0554		
F0572 SS = C	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.	F0572	On 3/9/26 all Resident Rights Posters were updated. The policy for Resident Rights was reviewed and revised by 3/17/26. Education was provided to administrative staff regarding posting of resident rights and where to obtain newly released state and federal language online by 3/24/26. Monitoring for updates has been added to the Quarterly QA&I Committee agenda for ongoing monitoring and further action.	03/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

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F0572 SS = C	Continued from page 3 §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 64 residents currently residing in the facility as well as all staff and visitors. Findings include: During observation on 3/3/26, at 11:45 a.m. the Resident Bill of Rights poster, dated 1/2019, was observed near the entrance to the building. A second Combined Bill of Rights poster, dated 1/2016, was posted next to the elevator going to the second floor. During interview 3/4/26, at 3:29 p.m., administrator stated she was unaware of the newly released Resident Bill of Rights poster, effective 1/1/26, which was to replace any previous posters. The facility policy, effective 8/1/21, titled Resident Rights, was reviewed, and identified residents had the right to be informed by the facility of rights granted within the Bill of Rights, which was to also include the recourse residents had if rights were violated. The policy identified the Bill of Rights were to be posted in a conspicuous location within the facility.	F0572		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F0577	On 3/5/26 the last annual Life Safety Code results were posted on all areas where survey results are made available and accessible to the public. On 3/17/26 a policy was developed and released to address the	03/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

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F0577 SS = C	Continued from page 5 Administrator stated it was important for the survey results to be available for review by residents, staff and visitors for so they may be aware of the previous survey results. A request was made for the facility policy for posting of survey results, however, a policy was unavailable.	F0577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Winona Manor	**865 MANKATO AVENUE , WINONA, Minnesota, 55987**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/2/26 to 3/5/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		03/26/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H52404923C (1064647) and H52404922C (2617715). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.	21565	On 3/4/26 staff removed the medication from R8’s room. The policy for Self-Administration was reviewed and revised by 3/23/26. An audit of all resident rooms was completed by a member of the nursing team by 3/24/26 to locate any other unordered medications in all resident rooms. All defects were reported to the nurse for prompt investigation and follow-up. Education to all nursing staff will provided by 3/31/26 . An audit of five resident rooms, will occur weekly x 5. All results will be shared with the QA&I Committee for further action.	03/24/2026

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21565	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed for 1 of 1 resident (R8) reviewed for self-administration of medication. Findings include: R8's Quarterly Minimum Dat Set (MDS) assessment, dated 2/10/26 indicated R8 was cognitively intact. Further, R8 was independent with eating and basic personal hygiene and dependent on facility staff for mobility and transfers. R8's record lacked an assessment to self-administer medications. During observation and interview on 3/2/26 at 7:01 p.m., a Voltaren Gel (pain relief) tube was observed sitting in a basket on R8's tray table. R8 stated he used the Voltaren Gel on both his knees when he had pain. R8 stated he would use the gel throughout the day and is unsure how many times per day. R8 lacked an order for Voltaren Gel. During observation and interview on 3/4/26 at 8:54 a.m., licensed practical nurse (LPN)-A was observed administering R8's morning medications. The Voltaren Gel remained in the basket on R8's tray table. R8 again stated, he uses the Voltaren Gel on his knees when they are causing him pain. LPN-A completed R8's medication administration and left the room. During an interview on 3/4/26 at 9:01 a.m., LPN-A stated she was unsure if R8 had an order for the Voltaren Gel and if he had been assessed to administer the medication himself. Upon review, LPN-A confirmed R8 had neither an order to use the Voltaren Gel nor an assessment to be able to self-administer the medication. LPN-A stated it is important to have an order for the Voltaren Gel, so the provider team knows all the medications R8 was taking. LPN-A indicated it is important R8 have an assessment to administer his own medication to make sure he is capable to administer the medication and that he can administer the medication as directed by the order. During an interview on 3/4/26 at 11:15 a.m., nurse manager (NM)-A stated medications such as Voltaren Gel should have a provider order. Further, if the resident would like to administer the medication themself, they	21565		

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21565	Continued from page 3 would need to be assessed to make sure they can administer the medication as directed by the medication order. NM-A stated if a nurse found a medication in a room, she would expect the nurse to follow up to make sure there was an order for the medication, and the resident had been assessed to have the medication in his room. NM-A stated it is important to have an order for all medications and residents are assessed to give the medication, this will ensure the providers are aware of all the medications a resident is taking, and to make sure the resident can safely administer the medication as ordered. During an interview on 3/4/26 at 2:19 p.m., the administrator/director of nursing stated all medications, even pain gels such as Voltaren Gel, need to have a prescriber order to administer. Further, if a resident would like to administer the medication, they would need to be appropriately assessed to ensure the resident can administer the medication as prescribed. The administrator/director of nursing stated if staff found medication in a resident room, she would expect them to verify the medication was ordered and remove the medication if it was not. Additionally, if the medication was ordered she would expect staff to verify if the appropriate self-administration assessment had been completed, removing the medication if it had not. During observation on 3/5/26 at 11:52 a.m., the Voltaren Gel remained sitting in a basket on R8's tray table. Additionally, an order for the Voltaren Gel had not been completed, and assessment for self-administration had not been completed. A facility policy titled Medication Administration dated 12/24, a resident may not be permitted to administer or retain any medication in his/her room unless it is so ordered by the provider and appropriate assessment is completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21565		
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4	21800	On 3/9/26 all Resident Rights Posters were updated. The policy for Resident Rights was reviewed and revised by 3/17/26. Education was provided to administrative staff	03/24/2026

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21800	Continued from page 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident Bill of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 64 residents currently residing in the facility as well as all staff and visitors. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21800	Continued from page 4 regarding posting of resident rights and where to obtain newly released state and federal language online by 3/24/26. Monitoring for updates has been added to the Quarterly QA&I Committee agenda for ongoing monitoring and further action.	