DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 960R

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00701

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245240**

2. STATE VENDOR OR MEDICAID NO. (L2) **020945700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE WINONA MANOR**
(L4) **865 MANKATO AVENUE**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/20/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **04/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **125** (L18)

13.Total Certified Beds **125** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	125			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/10/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **02/01/1982** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245240

January 10, 2017

Ms. Robin Hoeg, Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

Dear Ms. Hoeg:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 13, 2016 the above facility is certified for:

125 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 4, 2017

Ms. Robin Hoeg, Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

RE: Project Number S5240027

Dear Ms. Hoeg:

On November 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 16, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2016, effective December 13, 2016 and therefore remedies outlined in our letter to you dated November 18, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245240 Y1	A. Building B. Wing Y2	12/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0242	Correction	ID Prefix F0314	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.25(c)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0323	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/13/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 1/5/2016	SIGNATURE OF SURVEYOR 10160	DATE 12/20/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245240	A. Building 01 - MAIN BUILDING 01 B. Wing	12/16/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 11/02/2016	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 11/14/2016	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 11/14/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/17/2017	SIGNATURE OF SURVEYOR 35482	DATE 12/16/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 960R

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00701

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245240**

2. STATE VENDOR OR MEDICAID NO. (L2) **020945700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE WINONA MANOR**
(L4) **865 MANKATO AVENUE**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/03/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
04/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **125** (L18)

13.Total Certified Beds **125** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	125			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 12/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/03/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :
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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

November 18, 2016

Ms. Robin Hoeg, Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

RE: Project Number S5240027

Dear Ms. Hoeg:

On November 3, 2016, a standard 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 13, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 February 3, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 3, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		12/13/16

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

Electronically Signed | 11/28/2016

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.

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	245240	A. BUILDING _____ B. WING _____	11/03/2016

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LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 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
F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the physician had been notified timely of a decline in heath status for 1 of 1 resident (R196) reviewed for a death record. Findings include: R196 was admitted to the facility on 7/12/16 from the hospital with a partial list of diagnosis of end stage renal disease and needs dialysis, homeless, uncontrolled diabetes type II, and chronic pain according to the admission face sheet. Admission note dated 7/12/16 at 2:27 p.m. identifies R196 arrived to Lake Winona Manor alert, oriented and appeared in no acute distress. Progress note dated 7/13/16 at 4:49 a.m. , identifies R196 to be experiencing weakness, having difficulty walking and difficulty with balance. Progress note dated 7/17/16 at 9:58 p.m., identifies R196 to be sleeping in wheelchair throughout most of the shift, refusing cares, irritable with staff, taking only bites of supper and refusing to take evening medications. Progress note dated 7/18/16, at 11:30 a.m. identifies R196 to be lethargic, poor appetite, confused, complaints of not feeling well. Morning	F 157	R196 was discharged from facility 7/18/16. All residents are considered at risk for this deficiency. LWM will create standard work for physician notification by 11/28/16. All nurses will be trained on the new standard work by 12/13/2016. Five random audits will occur weekly x 5 by a gemba coordinator or designee for compliance. Audit results will be evaluated by QA&I for further action.	

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F 157	Continued From page 2 and midday medications were held due to R196 vomiting. Vital signs were obtained with a respiration rate of 30 and Oxygen saturation of 95% on room air. At 4:00 p.m. R196 was found to have died. Interview on 11/3/16, at 3:41 p.m. with registered nurse (RN)-B, who was the nurse working on 7/18/16, stated that she couldn't remember if the provider had been notified of R196's change in condition. Also the facility was asked for any information regarding the timely notification of the physician in regards to R196's deteriorating health status he exhibited on 7/18/16 the last 8 hours of life. None was provided by provider. Interview on 11/3/16, at 4:10 p.m. with the medical director stated she was assigned as R196's primary provider. Medical director stated she didn't recall being notified of R196's change in condition during his stay at the facility especially the last day of life. Requested facility policy on notifying provider of change of condition but was not received.	F 157		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine preferences	F 242	R106□s bathing preferences were updated in his plan of care on 11/2/16. All	12/13/16

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F 242	Continued From page 3 for bathing for 1 of 3 residents (R160) reviewed for choices. Findings include: R160's quarterly Minimum Data Set (MDS) dated 9/15/16, identified R160 had intact cognition and required one-person physical assist with bathing. On 10/31/2016, at 11:15 a.m., R160 stated he was not able to choose how often he took a bath or shower. R160 stated he would like a couple more baths/showers a week. On 11/02/2016, at 12:36 p.m. social services (SS)-A stated she thought the nurses had discussed bathing preferences with the residents upon admission. SS-A stated the residents could all ask the nursing assistants for additional showers, but it was based on aide availability that day. On 11/02/2016, at 3:25 p.m. social services (SS)-A stated she met with R160 and he did indicate he would like more than one shower a week. SS-A stated it would be care planned for R160 to have another shower per week and two showers a week would be implemented. On 11/02/2016, at 7:02 p.m. R160 stated a staff member visited with him today and stated he was going to have two baths a week. R160 stated, "Twice a week will be great." R160 stated he found out when his bath day was when a staff member came into his room and told him it was his bath day. R160 indicated he had not asked for additional baths per week nor had facility staff asked his preference.	F 242	residents are at risk for this deficiency. The admission assessment will be revised to include frequency of bathing by 11/28/16. All nursing and therapeutic recreation staff will be educated on bathing frequency requests by 12/13/2016. Five random resident audits will occur weekly x 5 by a gemba coordinator or designee for compliance. Audit results will be evaluated by QA&I for further action.	

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F 242	Continued From page 4 On 11/03/2016, at 9:49 a.m. registered nurse (RN)-A stated the aide goes through the resident checklist and daily routine with residents upon admission and discussed bathing. RN-A stated the residents typically have baths one time a week here and are told when their bath day is. RN-A stated the facility did not offer residents more than bath a week. RN-A stated if a resident requested additional baths a week, the request would be honored. On 11/03/2016, at 9:58 a.m. activities (A)-A stated activity staff did not ask how often R160 would like a bath. A-A stated we do talk to them about their preference of bathing, if they would like a bath, shower, or bed bath. A-A stated she did not discuss with residents their preference of how frequently they would like bathing. On 11/03/2016, at 10:26 a.m. the director of nursing (DON) stated during the admission process it was standard to ask bathing preferences of the residents. The DON stated the facility did have residents that have more than one bath. The DON stated as part of the care plan a residents' goals for bathing should be discussed. The DON stated she expected bathing frequency to be discussed as a part of the care planning process for residents. A policy was requested related to resident choices for bathing frequency and was not provided.	F 242		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		12/13/16

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F 314	Continued From page 5 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement assessed interventions to promote healing and prevent further pressure ulcers from developing for 1 of 3 residents (R26) reviewed with a current stage IV pressure ulcer. Findings Include: R26 was admitted to the facility on 7/1/16, according to the facility face sheet. R26's diagnoses included unspecified displaced fracture of first cervical vertebra, multiple sclerosis and dysthymic disorder R26's staff interview on 10/31/16 at 12:35 p.m. revealed R26 had a stage three pressure ulcer on her right heel. R26 was observed on 11/01/2016, at 12:14 p.m. in dining room sitting in wheelchair wearing tennis shoes, visiting with other residents at the dining room table. R26 was observed on 11/02/2016, at 12:43 p.m. in the dining room, sitting in her wheelchair wearing slippers with both of her feet placed on the floor.	F 314	R26□s nursing assistant task list was revised to include ordered footwear on 11/2/16. The wound care nurse evaluated current treatments and updated orders on 11/8/16. All residents pressure reduction devices are at risk for this deficiency. All nursing staff will be educated by 12/13/2016 regarding pressure reduction orders. The pressure reduction options in the electronic medical record orders will be revised on 11/28/16. Five random resident audits of pressure reduction compliance will occur weekly x 5 by a gemba coordinator or designee for compliance. Audit results will be evaluated by QA&I for further action.	

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F 314	Continued From page 6 R26 was observed on 11/02/2016, at 1:30 p.m. in her room, sitting in her wheelchair wearing slippers with both of her feet placed on the foot rests of her wheelchair. R26 was observed on 11/03/2016, at 8:01 a.m. sitting in her wheelchair at the dining room table wearing tennis shoes. R26's feet were both placed on the foot pedals of her wheelchair. R26's treatment sheet dated 10/26/16 included, Treatment: Heel lift boots/Prevalon boots to both heel/legs (offload heels at all times). R26's nursing assistant care plan dated 11/2/16, included heel lift boots on at all times, inspect skin during cares; report any changes to nurse. R26's nurse progress note on 10/17/16, indicated all skin was noted to be intact. R26's progress note dated 10/24/16, included skin alterations: Open lesion, nursing assistant notified writer of a sore on resident's left heel. Found an approximately 3 centimeter (cm) by 2 cm by 2 1/2 cm open sore that appeared to be pressure related. Cleansed and applied a 3 by 3 Mepilex. Will set up a treatment until healed. R26's progress note dated 10/25/16, included pressure ulcer: Unstageable (unable to determine how deep) wound bed covered by slough and/or eschar, quarter sized with black eschar covering surface with ring around eschar that is draining. Area dark purple discoloration to back of heel surrounding the ulcer. Mepilex applied and message sent to wound nurse.	F 314		

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R26's nurse progress note dated 10/25/16, included charting by registered nurse this morning with reason given; left heel ulcer. Resident is using a heel lift boot when in recliner and in bed.

R26's nurse progress note dated 10/26/16 included Push tool: location of the wound left heel, length by width 4.1-8 cm, exudate amount: moderate, tissue type slough total score 12.

R26's nurse progress note dated 10/26/16 included Pressure ulcer: Has full thickness of skin lost, exposing the subcutaneous tissues- presents as a deep crater pressure ulcer stage three. Location left heel length 2.0 cm, width 3.0 cm, depth 0.2 cm. Wound bed characteristics: pink granulating 40 yellow 60 other: 3.5 cm wide dark callous scab superior to wound. Drainage: serious sanguineous mixed with straw colored drainage. Odor: none, drainage amount moderate, periwound area intact, some callous. Current treatment: cleanse with safe cleanse, pat dry with gauze, cover wound Aquacel AG extra, secure with Mepilex 4 x 4" border and protect with heel lift boots, off-load heels at all times, use heel lift boots for right heel as well. Unknown how long this pressure ulcer has been present. Float heels with pillow if heel lift boots are not on.

R26's progress note dated 10/26/16 included wound nurse here this afternoon. New orders received to area on left heel. Aquacel AG and Mepilex border applied. Continues to wear heel lift/Prevalon boot to lower left extremity. Also applied to right lower extremity due to risk of skin breakdown.

On 11/03/16, at 8:11 a.m. nursing assistant

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(NA)-A stated R26 used a heel protector at night and we elevate her leg on a pillow so her heels are off the bed. NA-A stated during the day R26 wore regular gripper socks on her feet and sometimes she will wear her tennis shoes depending on her preference. NA-A stated the nurses communicated any changes to resident care plans verbally to the aides.

On 11/03/2016, at 8:17 a.m. NA-B stated R26 had a pressure ulcer on her left heel. NA-B stated staff needed to keep R26's legs elevated while in bed and try their best to keep pressure off of her heels. NA-B stated she dressed R26 that morning and stated R26 was wearing tennis shoes. NA-B stated slippers may have been a better choice as they would not have applied as much pressure on her heels as the tennis shoes. NA-B stated she should probably go switch the tennis shoes to slippers. When asked how she was made aware of changes to resident care plans, NA-B stated honestly, I would not know if I did not hear in report or if the nurse did not communicate it to me. NA-B stated she did not normally work on this floor and stated she did not have time to read R26's nursing assistant care plan that morning.

On 11/03/2016, at 8:29 a.m. licensed practical nurse (LPN)-A verified through observation R26 to be sitting at the dining room table wearing tennis shoes with both feet placed on her wheelchair pedals.

On 11/03/2016, at 8:31 a.m. registered nurse (RN)-A verified by observation R26 was sitting in her wheelchair, at the dining room table wearing tennis shoes, both feet were placed on the foot pedals of the wheelchair. RN-A stated R26 was only to wear the Prevalon boots when she was in

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her recliner or in bed. RN-A verified per the treatment order dated 10/26/16 and per the nursing assistant care guide dated 11/2/16, R26 should have had the Prevalon boots on both of her feet at all times. RN-A stated the nursing assistants printed nursing assistant assignment sheets that instructed them to complete specific tasks during their shifts and verified the Prevalon boots were not on the nursing assistant assignment sheets for R26. RN-A verified the Prevalon boots were not added to the nursing assistant care plan until 11/2/16.

On 11/03/2016, at 9:30 a.m. the director of nursing (DON) stated her expectation was staff were to follow the treatment orders in place for R26's pressure ulcer. The DON stated any instructions for nursing assistants would be on their task list and nursing assistant care plan and they are expected to be kept updated and used to complete the cares. The DON stated the nurse on the floor was to work with the care team and make decision to update and make changes to the care plan. The DON stated the nursing assistant care guide should have been updated on 10/26/16 per the treatment orders for any skin changes. The DON stated wound measurements for pressure ulcers were done at most weekly. The DON stated wound measurement should have been completed on 11/2/16.

The Lake Winona Skin Care policy last revision date of 8/15/16 included: " ...IV. When a skin ulcer or other wound is identified, a comprehensive wound assessment will be completed and documented in the electronic medical record by the charge nurse or nurse on duty. CNA [certified nursing assistant] should report any skin changes to licensed nurse.

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F 314	Continued From page 10 This assessment will include: A. Measure pressure ulcer or other wound or bruising. Noting condition of wound bed, condition of the surrounding tissue and any/other s/sx of infection. B. Treatment of wound or pressure ulcer being implemented. C. A review of the resident's current POC and medical status- any other possible risk factors, (i.e. impaired healing due to diagnoses); to be identified. D. Identify type of skin ulcer; MD/NP/Wound specialist is asked to identify type of ulcer, (e.g. pressure, stasis (venous), ischemic (atrial), or neuropathic), and provide wound treatments orders as needed. E. Reassess the wound at least weekly; including Steps a-c above until healed... V. Nursing personnel will develop a POC with specific risk, wound locations and interventions identified, nursing personnel will monitor response to the POC and ensure implementation of the POC ... "	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 323	A smoking assessment will be created	12/13/16

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F 323	Continued From page 11 review, the facility failed to complete a safe smoking assessment for 2 of 3 residents (R28, R13) who were unsupervised when they smoked while residing in the facility. Findings include: R28 and R13 had been observed on 11/1/16, at 11:00 a.m., they were observed outside the facility smoking cigarettes near the side walk. the two resident were in wheelchairs and were observed to safely handle smoking materials. A smokeless ashtray was present just off sidewalk for disposal of cigarette butts and no cigarette butts were noted on ground near the smoking area. At this time R28 was able to used an electric scooter and independently go outside of the building. There were no burn holes or unsafe smoking noted by the surveyor during these observations. R28 according to A Lake Winona Manor, Resident Face Sheet indicated R28 was admitted May 22, 2016. A quarterly Minimum Data Set (MDS) dated 9/22/16 indicated R 28 had intact cognition and was independent with locomotion off unit. R28's care plan dated 10/1/16, identified risk for falls due to limited mobility, weakness and pain but did not identify risk for safety related to smoking, nor was there evidence of an assessment for smoking safety. R13 according to A Lake Winona Manor Resident Face Sheet indicated R13 was admitted to the facility on July 7, 2016. A quarterly MDS dated 10/20/16 indicated R13 had intact cognition and was independent with locomotion off unit. R13's care plan identified a self care deficit related to history of stroke and paralysis to her dominant	F 323	and completed for residents who are found to smoke at the edge of campus, including residents R13 and R28 by 12/4/16. All nurses will be educated on the new assessment standard work by 12/13/2016. A random audit of residents observed smoking will be performed by the Gemba Coordinator or designee weekly x 4 to ensure compliance. Audit results will be evaluated by the QA&I Committee for further action.	

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side requiring set up help from staff. The care plan further indicated a potential for safety risk related to difficulty removing self from unsafe situations, but indicated she had the ability to propel self when in wheelchair from inside facility to off property and back to smoke multiple times daily. R13's care plan did not identify risk for safety related to smoking, nor was there evidence of an assessment for smoking safety.

During an interview on 11/02/16, at 2:18 p.m. while R28 was sitting in her recliner in her room. She stated the facility staff had not observed her smoking and stated she could smoke whenever she wanted as long as she was off facility property. R28's clothing was not noted to have any burn holes.

During an interview on 11/3/16, at 3:06 p.m. in regards to R28 and R13 smoking, the director of nursing (DON) stated the facility did not do any assessment(s) for smoking safety and stated, "It is not our intention to make sure they are safe when they are smoking." She further stated that resident and families are told the facility was a non smoking campus and are asked to sign an admission agreement which states that Lake Winona Manor is a tobacco free facility. Our residents that choose to smoke have to go off grounds. We are not going to allow smoking on campus. Once they are off campus and smoking we are not necessarily responsible for that behavior.

A facility document titled Tobacco-Free Campus /Resident Handout, revised September 2016, indicated Winona Health Campus was a Smoke Free and Tobacco Free Facility. No on campus smoking was allowed. If failure to follow

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	245240	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE WINONA MANOR	**865 MANKATO AVENUE WINONA, MN 55987**

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F 323	Continued From page 13 smoke-free policy will result in discharge or removal from Winona Health Property.	F 323		

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	245240	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Lake Winona Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/28/2016

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Winona Manor is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1962 and 1964 was determined to be of Type II(111) construction. In 2000, addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the 1962 and 1964 buildings and the 2000 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 125 beds and had a census of 107 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293	NFPA 101 Exit Signage	K 293		11/2/16

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K 293 SS=F	Continued From page 2 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that exit and directional signs are displayed in accordance with 7.10 .This deficient practice could affect 107 of the 107 residents. Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) FINDINGS INSCLUDE: On facility tour between 10:00 AM and 2:00 PM on 11/01/2016, observation revealed the door leading to the Lakeville Courtyard is not designated as an exit. This door needs to be marked "No Exit". This deficient practice was verified by the Facility Maintenance Director.	K 293	Work Order FAC-70920. Installed sign on door. No other similar "non-exit" doors exist.	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing	K 918		11/14/16

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K 918	Continued From page 3 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 107 of 107 residents. Electrical Systems - Essential Electric System	K 918	Work Order FAC-70987. Made preventative maintenance work order more clear on what is needed and set up training with Engineer. Audit of the new documentation will occur on 11/14/16 to monitor compliance. Audit results will be communicated to the QA&I Committee for further action.	

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K 918	Continued From page 4 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INSCLUDE: On facility tour between 10:00 AM and 2:00 PM on 11/01/2016, Monthly Generator Test documentation revealed that the transfer time from normal power to emergency power is not consistently being documented on the Generator	K 918		

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K 918	Continued From page 5 Test Log. This deficient practice was verified by the Facility Maintenance Director.	K 918		
K 920 SS=F	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 107 of the 107 residents. Electrical Equipment - Power Cords and Extension Cords	K 920	Work Order 70921. Extension cord removed by 11/14/16. Audits of all common areas occurred on 11/14/16 for compliance. Audit results will be communicated to the QA&I Committee for further action.	11/14/16

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K 920	Continued From page 6 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INSCLUDE: On facility tour between 10:00 AM and 2:00 PM on 11/01/2016, observation revelaled an extension cord being used as a source of fixed wiring in the TCU Common Dining Room. Two food warmers were observed plugged into an extension cord. This deficient practice was verified by the Facility Maintenance Director.	K 920		