

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 23, 2019

Ms. Linda Atkinson, Administrator Lake Winona Manor 865 Mankato Avenue Winona, MN 55987

Re: Lake Winona Manor - Independent Informal Dispute Resolution CMS Certification Number (CCN) 245240 Project # S5240030

Dear Ms. Atkinson:

In a request dated February 8, 2019, Lake Winona Manor requested removal of a deficiency cited at F686 as a result of a survey completed on November 2, 2018 by the Licensing and Certification program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated April 10, 2019.

The revised CMS 2567 is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Becky Wong

CC: Office of Ombudsman for Long-Term Care Mary Absolon, Program Manager Pam Kerssen, Assistant Program Manager Maria King, Assistant Program Manager Brenda Fischer, Assistant Program Manager Lindsey Krueger, OHFC Director Licensing and Certification File

IIDR - Revised 2567

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-	OMB NO	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E SURVEY IPLETED
		245240	B. WING	11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(X5) COMPLETION DATE
E 000	Initial Comments		EC	000	
E 035 SS=C	Preparedness Requ October 29, 30, 31, during a recertificat in compliance with Preparedness Requ LTC and ICF/IID Sr CFR(s): 483.73(c)(4 [(c) The [LTC facility and maintain an em communication plan State and local laws updated at least an plan must include at (8) A method for sh emergency plan, th is appropriate, with families or represen This REQUIREMEN by: Based on interview facility failed to ensi preparedness plan information the faci appropriate, with cli representatives. Th 89 residents current their families/represent Findings include: On 10/31/18, at 1:3 policies and proced registered nurse (R	aring Plan with Patients a) y and ICF/IID] must develop hergency preparedness in that complies with Federal, is and must be reviewed and nually.] The communication II of the following: aring information from the at the facility has determined residents [or clients] and their ntatives. NT is not met as evidenced y and document review, the ure their emergency included a method for sharing lity had determined ents and their families or is had the potential to affect all tly residing in the facility and	EC	E-035 Standard work for family notification of facility emergency plans will be created on 12/4/2018. The Lake Winona Manor Emergency Prep Policy will be updated to include notification of plan to residents and responsible parties by 12/4/2018. LWM staff will be educated on updates to standard work and policy by 12/11/18. A social worker or designee will audit perform a monthly audit x 4 months to monitor compliance. Results will be brought to the QA/QI for further recommendations.	12/11/18
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE
Electron	ically Signed				11/30/2018

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.

PRINTED: 04/23/2019

				DEPARTMENT OF HEALTH AND HUMAN SERVICES						
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		0938-0391				
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED				
		245240	B. WING		11/(02/2018				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	2,2010				
	NONA MANOR			865 MANKATO AVENUE						
				WINONA, MN 55987						
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
E 035	Continued From pa	ge 1	E 03	5						
	their families or rep	-								
F 000	INITIAL COMMENT	ſS	F 00	0						
F 557	standard survey wa the Minnesota Depa if your facility was in requirements of 42 Requirements for L The facility's plan of as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has beet your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with	F 55			12/11/18				
SS=E	CFR(s): 483.10(e)(2 §483.10(e) Respec	2) t and Dignity. right to be treated with respect								
	§483.10(e)(2) The r possessions, includ as space permits, u upon the rights or h residents. This REQUIREMEN by:	right to retain and use personal ling furnishings, and clothing, unless to do so would infringe lealth and safety of other NT is not met as evidenced tion, interview, and record		F557 Respect/Dignity						

Facility ID: 00701

If continuation sheet Page 2 of 101

PRINTED: 04/23/2019

		& MEDICAID SERVICES	(X2) MU				0938-039 SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245240	B. WING			11/0	02/2018	
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987			
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 557	Continued From pa	age 2	F 5	57				
	 (R42) was treated being provided ass Findings include: R42's Face Sheet of admit date of 5/18/ sclerosis (MS), dep R42's quarterly Mir assessment, dated intact cognition, red assist with dressing person extensive at transfers. R42's care plan up problem: I need as daily living (ADL's) Approach: persona approaches I am m with deviation from sexual assault and me feel vulnerables they are being prov female care givers care. Problem: I ca controlling of other as this is how I cop taking time to lister 	ailed to ensure 1 of 1 resident in a dignified manner while istance with personal cares. dated 11/1/18, identified an 17, a diagnoses of multiple pression and anxiety. himum Data Set MDS an 8/30/18, identified to have quired 1 person extensive g and personal hygiene, 2 ssist with bed mobility and dated 10/19/18, identified a sistance with my activities of because I have MS. I history-as evening hore tired and may not cope my routine. I have a history of at times incidents can make . Please explain all cares as vided. I am ok with male and to complete all parts of my an be demanding and s. I may have verbal outbursts with my MS. Approach: n to what I have to say, t is helpful and calming.			Resident 42 s care plan was upda 10/18/2018 and reviewed for accur 11/29/2018. Employee involved in situation received coaching on 10/19/2018. The VA Policy and sta work were reviewed and updated of 11/27/2018. All LWM staff will be t on VA Policy by 12/11/2018. Rand Audits of 5 staff will occur weekly x weeks by the Social Worker or Des to monitor compliance. Results wi brought to the QA/QI for further recommendations.	andard andard on rained om 5 signee		
	p.m., indicated, Re staff member telling him in there or eve	arting dated 10/17/18 at 10:47 sident was rude to the male g other staff she didn't want n want him to be in there to do e aide was in the room. Stated						

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED
		245240	B. WING	;		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 557	vacation because y here." And he left w the last to go to bec Behavior record cha a.m. indicated, resi- cares, stating the a towards her. Aide y felt like I was being my shirt, I would as Night aide allowed few minutes later, r alcohol, stated to re put on the call light. Behavior charting d indicated, due to co raped' this writer ar nurse) came to talk if she felt threatene responded, "No I ar just grabs and start ready. "Writer aske doing these things just starts grabbing washcloths ready a goes so fast and I f " Writer paraphra what you are saying without seeing what does not tell you wh you know what is co that is what he does just do not mesh we the resident say "yo you felt he was graf were being rape? F	ou bother everyone around with his partner and she was arting dated 10/18/18, at 12:07 dent was upset about her p.m. ides "weren't being friendly was pulling on my shirt and it raped. If I needed help with k for help, I can do it myself." resident to let out feelings. A esident asked for some hard esident if you need anything to	F 5	557			

Facility ID: 00701

If continuation sheet Page 4 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION		(X3) DATI	E SURVEY IPLETED
		245240	B. WING	з_			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 557	the person grab me suggested that due she be ok with fema updated, resident is except in case of er can be used to help During interview on stated, nursing assi disrespectful toward around 6:30 p.m. I had given me some found out one of my diagnosis may not i what happened was my room to help me the process of takin stated, No, I will get top on it hit me all w for help if I needed seems like he is alw proceeded to tell hi my shirt, this is the should know it has then backed off and me disrespect!" He pointed towards the and [NA-M] follower in till 9:45 p.m. that [licensed practical r room and said very getting you ready for not, so I don't want being disrespectful her mind up, she w made me feel like I She had been in he	past where I was raped and e similar to this." Writer then to past and situation would ale only care giver. Care Plan a female only care giver mergency a male care giver o assist resident. 10/30/18, at 9:21 a.m. R42 stant (NA)-N was ds me about a week ago had a bad day, my nephew e bad news and I had just y good friends with a cancer make it through the night. So is NA-N and NA-M came into e get ready for bed. I was in ng off my shirt and NA-N t it When he went to pull my vrong. I told him I would ask it, and he said, ok, ok! It ways in a big hurry, so I m, as he was trying to tug at way guy's rape women, and I happened to me twice. He d told me, "You will not show then snapped his fingers and e door and went out the door d him. They didn't come back night. Then my nurse, nurse (LPN)-F] comes in my sternly to me, "[NA-N] will be or bed whether you like it or to hear anymore that you are to him." [LPN-F] had made as siding with [NA-N] and "It was reprimanded like a child."	F	55				
	not, so I don't want being disrespectful her mind up, she w made me feel like I She had been in he	to hear anymore that you are to him." [LPN-F] had made as siding with [NA-N] and "It was reprimanded like a child."						

If continuation sheet Page 5 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	3		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 557	clock. I was not ex talk to me like that, by both of them. We NA-N helped me in helping me. I am n NA-N, he is on vaca with him. You learn or no way. They ac him, I was just havi the mood to have m next morning [social talked with me, whe he told me they we NA-N blew it way of telling them that I sa that was not at all w (A)-B] came and as told her it was a PT disorder) thing with shirt. She then told someone to talk to came in and talked R42 stated, "I do no I just want to be treat feel like no one her During phone interv nursing assistant (N find R42 difficult, bu points are valid, sor time getting her poi one of my co-worke on R42's wing. I th him because he wan night before, and w hold grudges. Any and R42 yelled at h go to Mexico! (She	pecting her to come in and I feel like I was disrespected ell they both came back and to bed and then NA-M finished ot worried right now about ation, so I haven't had to deal around here that it is their way sted like I was screaming at ng a bad day and I wasn't in ny shirt pulled like that. The al services (SS-B] came in and en I told him what happened re wrong in doing that. I think ut of proportion, I think he was aid he tried to rape me and what I said. Then [administrator ked me what happened and I SD (post traumatic stress n [NA-N] when he grabbed my me they would get me for that. No one else ever to me about it, that was it. of feel like [NA-N] abused me, ated with respect and dignity, I	F	557			

If continuation sheet Page 6 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING	Э		11/(02/2018
NAME OF	PROVIDER OR SUPPLIER	-		;	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	٦I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 557	inappropriate. Ther not disrespect me I this way, in a very s half on. Then he sa leaving. I thought it me finish putting he suppose [R42] tried through the commo and off, she has an to the trans care un put my shirt half wa stated, I did go bac asked if she was re- her to bed. [R42] w and told me she wa NA-M verified no of her about this spec told [registered nurs make sure we char I do think it was dis shirt half on and ha walk out with him, w helping her. During interview on verified the incident during the evening the following mornin know NA-M and NA incident and did nor I would say leaving off was disrespecting done. During interview on stated he was not a concerning R42. S was not handled we	nge 6 n [NA-N] said to [R42], you will like that, you will not treat me stern voice and left her shirt aid to me, come on we are was wrong, he should have let er shirt all the way on, I to make us look bad, going on area with her shirt half on electric wheelchair and went hit (TCU), telling people, they by on then left me. NA-M k in there a while later and eady for bed, and we helped vas still very upset with [NA-N] as not going to talk to him. ther staff came and talked to ific incident. The next day we se (RN)-F] and she told us to t this as a behavior, so we did. respectful that [NA-N] left her If off and demanded me to when I could have finished 11/01/18, at 2:22 p.m. RN-F t happened on 10/17/18, shift and that she was notified ng. RN-F verified she did A-N were involved in the t interview them. RN-F stated, [R42's] shirt half on and half ul, that should not have been 11/01/18, at 2:39 p.m. SS-B aware of the whole situation S-B stated, I feel the situation ell, it is their job to care for the ever should have been left	F	557			

If continuation sheet Page 7 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 04/23/20 FORM APPROVI MB NO. 0938-03	ED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/02/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC	лс
F 557	half on, and cares of dignity, you can't just shirt half on." During interview on verified she went ar morning she was no stated, I will have to before I could say if disrespectfully. A-E	250me first. "It does go back to st leave someone with their 11/01/18, at 3:14 p.m. A-B nd talked with R42 the otified of the incident and interview the staff members this resident was treated B further stated, R42 did e room with her shirt half off,	F 557			
F 585	During interview on of nursing DON sta about this incident, on that and closed to residents to be trea They (the staff) strue behaviors and we a vulnerable adult and treat her with respe we have some work Policy requested re provided. Grievances	11/01/18, at 4:39 p.m. director ted, I was notified right away the administrator followed up the loop on that. I want all my ted with dignity and respect. toggle with the right tools for her the working at that. "She is a d we have to care for her and ct and dignity and it is obvious < to do."	F 585		12/26/18	3
SS=E	§483.10(j) Grievand §483.10(j)(1) The re grievances to the fa that hears grievanc reprisal and without reprisal. Such griev respect to care and furnished as well as					

Facility ID: 00701

If continuation sheet Page 8 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245240	B. WING	i		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From paresidents, and othe facility stay. §483.10(j)(2) The refacility must make presolve grievances accordance with thi sector accordance with this sector accordance with this sector accordance policy to a fall grievance policy to a fall grievance policy to a fall grievances regulated in this parent facility of the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance offican be filed, that is, address (mailing ar number; a reasonal completing the revise to obtain a written of the grievance of the grievance of the revise to accord	sc IDENTIFYING INFORMATION) age 8 r concerns regarding their LTC esident has the right to and the brompt efforts by the facility to the resident may have, in is paragraph. acility must make information evance or complaint available acility must establish a ensure the prompt resolution garding the residents' rights aragraph. Upon request, the a copy of the grievance policy e grievance policy must at individually or through ent locations throughout the o file grievances orally or in writing; the right to file hously; the contact information ficial with whom a grievance , his or her name, business and email) and business phone ble expected time frame for ew of the grievance; the right decision regarding his or her	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	independent entities be filed, that is, the Quality Improvement Agency and State L program or protectin (ii) Identifying a Grie	contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey Long-Term Care Ombudsman on and advocacy system; evance Official who is rseeing the grievance process,					

If continuation sheet Page 9 of 101

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	receiving and track conclusions; leadin by the facility; main information associa example, the identii grievances submitted written grievance de coordinating with st necessary in light of (iii) As necessary, t prevent further pote right while the allege investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statemen the steps taken to i summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropria accordance with St of the residents' rig or if an outside entii the State Survey Ag Organization, or loc confirms a violation	ing grievances through to their g any necessary investigations taining the confidentiality of all ated with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and tate and federal agencies as of specific allegations; taking immediate action to ential violations of any resident yed violation is being \$483.12(c)(1), immediately d violations involving neglect, juries of unknown source, ation of resident property, by services on behalf of the ministrator of the provider; and	F 585			

If continuation sheet Page 10 of 101

		& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		0938-039 SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	· /	G		PLETED	
		245240	B. WING		11/02/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 585	Continued From pa	ge 10	F 58	5			
	result of all grievand 3 years from the iss decision. This REQUIREMEN by: Based on observat review, the facility fi implement a grieva residents (R8, R17, R25 and R50) revie Findings include: During a resident co present with R8, R7 R25 and R50, on 10 asked if anyone know who their grievance attendance stated to grievance or who th the exception of R1 forms on the doors you fill out the form back to you. R82 st years and I never h grievance." When on grievances all re- with stating, "No." a had confused looks they do not respond half the time we do were nodding their said this. At 10:40 not always act pron complaints/grievand repeat it to the head (department heads	dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview, and record ailed to communicate and nce process for 9 of 9 , R82, R3, R41, R43, R49, ewed during resident council. ouncil meeting without staff 17, R82, R3, R41, R43, R49, 0/31/18, at 10:30 a.m. when ew how to file a grievance or e official was 8 of 9 residents in they did not know how to file a ne grievance official was, with 8. R18 stated there are paper of the social workers and that and the social worker will get cated, "I have been here for 7 eard of being able to file a asked if the facility follows up esidents were in disagreement and shaking their heads. A few s on their faces, R43 stated, d to our concerns, that's why n't repeat it. Several residents heads in agreement as R43 a.m. R41 stated, no, they do nptly to our ces, sometimes you have to d of one of the committees) whoever you are having the ometimes you can't discuss		F 585 Grievances A policy and form for LWM Grieva was created on 11/30/2018. ALL I staff will be trained on new standar by 12/11/2018. Updated Standard for resident grievance education of by 12/4/2018. All residents and responsible parties will be trained grievance process by 12/26/2018. of resident care conferences will be x 8 weeks by a Social Worker or Designee to determine level of understanding. Results will be bro the QA/QI Committee for further recommendations.	LWM rd work Work reated on Audits e done		

If continuation sheet Page 11 of 101

		AND HUMAN SERVICES				FORM): 04/23/2019 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245240	B. WING	<u> </u>		11	/02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 585	Continued From pa certain things in fro	•	F	585	5		
	unit coordinator (Hl grievances are ente	10/31/18, at 12:14 p.m. health JC) stated, resident ered into ECS (electronic as not sure if there was a					
	asked about how a grievance, licensed stated, we do not h a res had a compla aide would tell me a "I think they have a was unsure and dir director of nursing.	10/31/18, at 12:16 p.m. when resident would file a practical nursed (LPN)-C ave paper grievance forms, if int they would tell the aide, the and I would document in ECS, grievance file there." LPN-C ected this surveyor to the	C				
	registered nurse (R grievances are filed (program in electro used more for fami resident has a com assurance (QA) (ar health record) unde official is, I guess it is. We do not have a resident has a co assistant has no wa a grievance form be access to the qualit nursing assistant on it to the nurse so sh Assurance in ECS grievance will not g	10/31/18, at 2:50 p.m. N)-A stated resident I under logic manager nic health record). This is ly grievance process. If a plaint we chart it in quality nother program in electronic er ECS. I think our grievance depends on what the concern 1 specific grievance official. If ncern I guess the nursing ay to help the resident to fill out ecause they do not have by assurance in ECS. The r resident would have to report the could put it in quality for investigation. The resident et a letter like the family am not sure why there are two or this.					

If continuation sheet Page 12 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING	;		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	During interview on assistant (NA)-L sta grievance form for f been here since Jun During interview on nursing assistant (N resident who had a trained medication a they would report it would be down on t the evening shift. I a followed up on. During interview on licensed practical n response to resider aide came to me ar to file a grievance of would ask the charg form." LPN-E was grievance system w charge nurse. During interview on registered nurse (R resident complaint/g resident would have they would put it in sure how a TMA wo If it is a complaint for than nursing we wo manager. This is th receive a letter in re With nursing conce not documented. During interview on	11/01/18, at 9:13 a.m. nursing ated, I don't think there is any he residents to use and I have	F	585			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245240	B. WING		11/	/02/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 585 F 607 SS=D	since 2013, when a process of how a re- who the designated action is taken to re- verified the policy d for grievances. Facility policy, Patie complaint Winona H indicated the purpo- of all negative feedl and to initiate corre- Patients will be info In the event a feedl resolution of the gri- person in writing. F should be addresse originates. When n it is entered into the (Logic Manager) as department director (No further plan ide Develop/Implement CFR(s): 483.12(b)(1) §483.12(b)(1) Prohi- neglect, and exploit misappropriation of §483.12(b)(2) Estat to investigate any s §483.12(b)(3) Inclu- paragraph §483.95	sked what the policy or esident files a grievance, and grievance official is and what solve the grievance, the DON oes not have a clear process ent/Resident Grievance and /or health policy, revised 4/18, se: requires prompt reporting pack for timely investigation ctive actions as appropriate. rmed of any follow up actions. back is a grievance, the final evance must be given to the Policy: negative feedback ed at the level and at the time it egative feedback is received, e electronic reporting system soon as possible. The r, manager or supervisor will 0. ntified). Abuse/Neglect Policies 1)-(3) ility must develop and policies and procedures that: ibit and prevent abuse, ation of residents and resident property, blish policies and procedures uch allegations, and de training as required at		585		12/11/18

	13 FUR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From pa	age 14	F 60	7		
	facility failed to ens policy and procedu resident-to-resident procedures for resi has the potential to building. Findings include: Review of The Vuln Plan with a revision policy did not include resident abuse. The Facility flow sh Altercations dated resident act willfully included the definiti intended the action should have known pain or mental angumay have cognitive commit a willful act that if the willful act that if the willful act tharm, pain, or men reportable. During an interview social services (SS Vulnerable Adult At include a definiti abuse)." SS-A state was a flow sheet for	v and document review, the ure their abuse prohibition res identified a definition of t abuse and reporting dent-to-resident abuse. This effect all 89 residents in the herable Adult Abuse Prevention date of 3/18, revealed the de a definition of resident-to neet for Resident-To-Resident 7/2014, included, "Did the v in the altercation?" and ion of "willful" as the individual itself that he/she knew or n could cause physical harm, uish. Even though a resident impairment, he/she could still the flow chart directed staff did not result in physical tal anguish, the act was not v on 10/31/18, at 2:50 p.m. c)-A verified by reviewing the puse Prevention Plan, it did not of resident-to resident abuse. ss I am not seeing it either on of resident-to resident ed at the nurse stations there or resident-to-resident ft to follow. SS-A stated the		F607 Develop and Impleme Abuse/Neglect Policies The LWM VA policy was upo current definition of resident abuse on 11/27/2018. All LV be trained on VA Policy by 1 Random audits of behavior documentation will occur we monitor for compliance to re requirements by a Social Wd designee. Results will be bro QA/QI Committee for further recommendations.	lated with -to-resident VM staff will 2/11/2018. 5 rekly x 8 to porting orker or pught to the	

If continuation sheet Page 15 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT	E SURVEY PLETED
		245240	B. WING	<u> </u>		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 607	Continued From pa not report.	ge 15	F	607	7		
F 676 SS=D	The State Operation PP dated 11/22/17, as used in this defir individual mush hav individual mush hav harm." Activities Daily Livin CFR(s): 483.24(a)(1) §483.24(a) Based of assessment of a re resident's needs an provide the necessa ensure that a reside daily living do not di of the individual's of that such diminution includes the facility §483.24(a)(1) A res treatment and servi or her ability to carr living, including thos of this section §483.24(b) Activitie The facility must pro activities of daily livit §483.24(b)(1) Hygie grooming, and oral	on the comprehensive sident and consistent with the d choices, the facility must ary care and services to ent's abilities in activities of minish unless circumstances inical condition demonstrate n was unavoidable. This ensuring that: ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b) s of daily living. ovide care and services in ragraph (a) for the following ng:	F	670			12/11/18

If continuation sheet Page 16 of 101

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES		Pr		APPROVED
		& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245240	B. WING		11/(2/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	snacks, §483.24(b)(5) Com (i) Speech, (ii) Language, (iii) Other functiona This REQUIREMEN by: Based on observat review, the facility fa provided for oral hy residents (R34), rev living (ADLs). Findings include: R34's admission M 9/4/18, indicated R3 impairment, require hygiene and bathing not occur during en R34's care plan, da assistance with my included oral hygier bathing I would like it helps my back. R34's nursing assis bathing: dependent assist, resident required on the p.m. shift. O natural teeth on the independent with se	nation-toileting, g-eating, including meals and munication, including I communication systems. NT is not met as evidenced tion, interview and document ailed to ensure cares were giene and bathing for 1 of 5 viewed for activities of daily inimum Data Set (MDS), dated ad had moderate cognitive ed one assist with personal g and activity of bathing did tire period. ted 9/21/18, included I need ADLs and approaches he set up assist and for to try a whirlpool bath to see if stant care sheet included with one person physical uest tub bath one time a week ral care: upper full set, four bottom. Grooming:	F 676	F676 ADLS-Care plans and NA tas were reviewed and updated for R3- 11/29/2018. R78 no longer resides facility. Standard work for oral care the Resident S Personal Appearan Hygiene Policy were reviewed and updated on 11/29/2018. All nursing will be trained on new standard wor 12/11/2018. 5 random audits of bo care and bathing records will be performed weekly x 5 by the Nurse Manager or Designee. Results will brought to the QA/QI Committee for further recommendations	4 on at this e and nce and g staff rk by th oral be	

PRINTED: 04/23/2019

		AND HUMAN SERVICES				FORM	: 04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245240	B. WING	G		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE WI	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 676	stated they do not of anymore. I am was room. I only get a s the scoop is. I have and that was in the During interview on stated I do not alway teeth. I do not known not ask. They offer time I had my teeth ago. During observation R34 laid in bed dreas stated my upper de night. When asked mouth had been br R34 stated no, I sho at the time I was dr rush when they com R34's record identifit was documented for assistants: 9/10/18 bath given and 10/8 shower given. During interview on nursing assistant (N R34 with a.m. cares offered or brushed teeth when providin I gave R34 her upp or brush R34's natu During interview on	offer me a bath or shower hed up in the bathroom in my crub down. I do not know what a had my hair washed one time shower that I had once. 10/29/18, at 3:22 p.m. R34 by get help with brushing my / if that is my fault or not. I do once in a blue moon. The last brushed was a couple months on 10/31/18, at 8:26 a.m., ssed eating breakfast. R34 nture plate was cleaned last if her four natural teeth in her ushed this morning with cares, ould have had them brushed essed. Everything is in such a ne in to help you get dressed. fied the following information or bathing by the nursing tub bath given, 9/17/18 bed 8/18 hair shampooed and 10/31/18, at 9:19 a.m., NA)-B stated she had assisted s. When asked if she had R34's four bottom natural og morning cares, NA-B stated er denture, but I did not offer ural teeth. 10/31/18, at 3:30 p.m., the	F	67			
	director of nursing (10/31/18, at 3:30 p.m., the (DON) confirmed R34's care N stated the facility protocol for					

If continuation sheet Page 18 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 676 F 677 SS=D	and evening cares, request. DON state hygiene to be comp During interview on stated R34 received and the nursing ass of the bath under the the computer system During interview on DON reviewed R34 above three times of documented. DON documentation of a been completed for have missed chartin would not expect to documentation not DON stated if the re- would expect staff the The facility policy C Conferences, dated multidisciplinary app each resident's card the resident's optim psychosocial, function status. ADL Care Provided CFR(s): 483.24(a)(2) A res- out activities of daily	be completed with morning anytime needed and at d she would expect oral leted every a.m. or offered. 11/01/18, at 7:53 a.m., NA-C d a bath on Monday evenings istant's document completion e nursing assistant charting in m. 11/01/18, at 10:09 a.m., the 's record and confirmed the of bathing having been stated there was no other ny other times bathing had R34. DON stated staff may ng a bath for R34, but she see that many gaps of being completed for bathing. esident had refused, she o document the refusal. are Plans and Care 14/16, indicated a broach is used to individualize e plan to achieve and maintain al physical, communicative, onal, spiritual and emotional for Dependent Residents	F	76		12/11/18
	personal and oral h					

Facility ID: 00701

If continuation sheet Page 19 of 101

		AND HUMAN SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATI	E SURVEY PLETED
		245240	B. WING				11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		
	NONA MANOR				5 MANKATO AVENUE			
				W	INONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFJ TAG		PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 677	Continued From pa by: Based on observat review the facility fa assistance for 1 of activities of daily liv Findings include R78's Diagnoses Li diagnoses of malig constipation, and cl R78's annual Minim 10/11/18, indicated decision making we MDS further indicat assistance from two extensive assistance The MDS also indic incontinent of bladc a toileting program. R78's urinary incon Assessment (CAA) did not include a da indicated R78 requi was taking diuretic incontinence and ai to overflow incontin R78 had diabetes, stress incontinence indicated, "revise co R78's self-care defi plan dated 10/3/18, assist depending of every two hours and further directed stat toileting return later	age 19 tion, interview, and document ailed to ensure timely toileting 5 residents (R78) reviewed for ing. ist dated 11/1/18, included nant neoplasm of bladder, hronic renal disease stage 4. num Data Set (MDS) dated R78 cognitive skills for daily ere severely impaired. The ted R78 required extensive of o staff for transfer and ce from one staff for toileting. cated R78 was frequently der and bowel and was not on the tax was printed on 11/1/18, ate of completion. The CAA ired assistance with toileting, medication that caused urge nticholinergic's that made lead bladder cancer, and had e with urgency. The CAA also urrent care plan." icit care plan for toileting care directed staff to use 1-2 staff n R78's mood and to assist d as needed. The care plan ff if R78 was resistive to r and attempt again. R78's skin	F	577	F677 R78 s is no longer a facility. Toileting stand created on 11/30/2018 will be trained on the t work by 12/11/2018. weekly of toileting cor 6 weeks by the Nurse designee. Results wil QA/QI Committee for recommendations.	resident at th dard work was 3. All nursing toileting stand 5 Random au npletion will o Manager or I be brought t further	e staff ard dits ccur x o the	
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: IQ2C1	1	Faci	lity I D: 00701	If continuatio	n sheet P	age 20 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G		E SURVEY PLETED
		245240	B. WING	3 <u> </u>		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	care plan dated 10/ risk for impaired sk incontinence and di and dry and to appl incontinent episode R78's progress note Resident is totally of toileting needs. He will have bowel more gets him there in tir he needs to use the increasingly anxiou movement and that During an observat R78 laid in bed with assistant (NA)-E inco one assist or two as mood was in the mit to wake R78 up and and blankets. The tip pad and fitted botto saturated with urine gown were also satt entered the room to resistive to get out of R78's gown and rep sheet with a fresh of socks on R78's fee neither NAs offered nor did the attempt brief or linen.	4/18, indicated R78 was at in integrity related to rected staff to keep skin clean y barrier cream after any e dated 10/16/18, included: ependent on staff for all is incontinent of both, but he vements in the toilet if staff ne. He doesn't tell staff when e toilet, but becomes s when needs to have a bowel is a cue for the staff. ion on 10/31/18, at 7:38 a.m. his eyes closed. Nursing dicated sometimes R78 was a ssist depending on what his orning. NA-E attempted gently d folded down the top sheet op sheet, mattress protector m sheet were noted to be a. R78's incontinent brief and urated. At 7:47 a.m. NA-F o assist NA-E. R78 became of bed. While NA-F changed blaced the urine saturated top lean sheet, NA-E put new t. During the observation to take R78 to the bathroom to offer or change the soiled on 10/31/18, at 8:52 a.m. tempted to get R78 up again, ot ready to get up. NA-E she hy cares, however, the nurse	F	67			

If continuation sheet Page 21 of 101

		AND HUMAN SERVICES			FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 21	F 6	577		
	NA-E knocked on F laid in bed with his of NA-E stated R78 co R78 if he wanted to not respond. NA-E checking R78's line the restroom. During an observat registered nurse (R room. R78 was agr and allowed NA-F a morning cares. R78 pad, and fitted botto urine. During an interview NA-F stated she ha offered and/or chec and linen as she ha arriving in the room she would have kno during the first atter would have asked a linen. NA-F stated to attempted to be cha been offered toiletin changed. During an interview registered nurse (R supposed to be toil was in bed he was changed every two sometimes R78 dis	ion on 10/31/18, at 10:01 a.m. R78's room and entered. R78 eyes closed and snoring. buld sleep all day. NA-E asked o get up and get ready, R78 did then left R78's room without en or offering to take R78 to ion on 10/31/18, at 11:34 a.m. N)-C and NA-F entered R78's eeable to get up out of bed and NA-G to assist with 3's brief, mattress protector for sheet were saturated with on 10/31/18, at 11:43 a.m. id thought the other NA had sked and changed R78's brief ad been in there prior to her that morning. NA-F stated if own that was not completed mpt to get him out of bed, she and/or changed the soiled the linen should been anged and R78 should have ng and/or checked and hours. RN-A indicated played aggressive behaviors key, if R78 had behaviors the staff to leave and				

If continuation sheet Page 22 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 04/23/2019 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245240	B. WING		11	/02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987	
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677 F 684 SS=E	could not tell staff w bathroom. RN-A sta change and/or offer multiple times then should have been in During an interview director of nursing (offered toileting or of per the care plan. D was incontinent stat another hour to re-a garments and linen refusals of care to t with another interve Policy relating to ind requested and not in Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recein accordance with pro- practice, the compri- care plan, and the in This REQUIREMEN by: Based on observat review, the facility fa assessment/monitor	operative. RN-A stated R78 when he needed to use the ated it was expected staff toileting and if R78 refused the nurse or clinical manager nade aware. on 11/1/18, at 11:20 a.m. DON) stated staff should have checked and changed R78 as DON further indicated if R78 ff should not have waited approach to remove the soiled and should have reported the he nurse in order to come up ention. continence/toileting was received. care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered esidents' choices. NT is not met as evidenced ions, interviews and record ailed to provide ongoing wing or care for edema (fluid residents (R78, R7 & R73)	Fé	577	F684 Care plans for R7 and R73 were reviewed and updated to include edema monitoring instructions by 11/30/18 . R78 is no longe a resident at the facility. New standard	

Facility ID: 00701

If continuation sheet Page 23 of 101

STATEMEN	T OF DEFICIENCIES DF CORRECTION	KINGER SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		02/2010
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	complications. Also dressing change with the physician order failed to ensure a fa completed for 1 of visit to the emerger Findings include: EDEMA MONITOR R78's Diagnosis Lis diagnosis of conge hyperkalemia (high disease stage 4, ar R78's annual Minin assessment, dated cognitive skills for of severely impaired, congestive heart fa diuretic medication assessment period R78's physician or -Furosemide (diure (mg) twice per day -Tubular bandage/T stockings) to both I day and off at night R78's care plan dat diagnosis of CHF m management. The 9/15/18, directed st for any redness sig breakdown and upo needed, Ted stocki	 a the facility failed to ensure a as implemented as written per s for 1 of 1 resident (R1) and ollow-up physician visit was 1 resident (R34) following a ney room. ING: at dated 11/1/18, included stive heart failure, potassium), chronic kidney nd vascular dementia. num Data Set (MDS) an 10/11/18, indicated R78's daily decision making was identified the diagnosis of ilure (CHF), and received s during all days of the 	F	 84 work was developed on monitoring and Aseptic on 11/30/18. All resider necessity of edema moplans updated accordin staff will be trained on n and policy updates by 1 Weekly audits of 5 resid for edema checks will be the Nurse Manager or coweeks. Results will be QA/QI Committee for furecommendations. Provider Notification staupdated on 11/30/2018 related to discharge prorecommendations. All I staff and Health Unit Coeducated on standard w 12/11/2018. 2 Random work will be performed Coordinator or designed weeks. Results will be QA/QI Committee for furecommendations. 	Dressing Changes hts screened for nitoring and care gly. All licensed ew standard work 2/11/2018. dents appropriate e performed by lesignee x 6 brought to the irther andard work was to include actions vider visit Licensed Nursing bordinators will be vork by audits of standard by a Health Unit e weekly x 6 brought to the	

If continuation sheet Page 24 of 101

STATE MENT OF DEFICIENCIES (M) PEROIDERSUPPLENCIAN (M) DENTIFICATION NUMBER (M) DUILING (M) DUILING (M) DUILING AME OF PROVIDER OR SUPPLER 245240 B WING STREET ADDRESS, CITY, STATE, 2P CODE LAKE WINONA MANOR STREET ADDRESS, CITY, STATE, 2P CODE Street ADDRESS, CITY, STATE, 2P CODE PAND PEROVECKING VISIT EF RECEDE BY FULL TREET ADDRESS, CITY, STATE, 2P CODE Street ADDRESS, CITY, STATE, 2P CODE PAND PEROVECKING VISIT EF RECEDE BY FULL PERCENCORST PLAN FOR CORRECTION (C) CONCURSATION (C) CONCURSATION (C) CONCURSATION (C) CONCURSATION PAND PEROVECKING VISIT EF RECEDE BY FULL PERCENCORST PLAN FOR CORRECTION (C) CONCURSATION (C) CONCURS			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTY, STATE, ZIP CODE LAKE WINONA MANOR STREET ADDRESS, OTY, STATE, ZIP CODE Out Dig Counting of the state of				l` í				
LAKE WINONA MANOR B55 MANKATO AVENUE WINONA, MIN 55987 CMUID PREFIX TAG SUMMARY STATEMENT OF DEPICENCIES (EACH CORRECTIVE ACTION SHOULD BE RECLUZIONY OR LSC DENTIFYING INFORMATION) PREFIX TAG PREFIX PREFIX PROPERTY AND FORMATION) PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEPICENCY) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) F 684 F 785 S ANNUALL/SC SA Assessment 10/10/18, EDE MA INDICATE AT A DESCROSS OF ANTION PREFIX F 684 F 684 During an observation on 10/29/18, at 2:34 p.m. family member (FM)-A stated R78 has had before. FM-A was not sure if R78 record and treffic directive action Novever: stated the pas had before. FM-A was not sure if R78 record and usefice medication hovever: stated the masha the before. FM-A was not sure if R78 record and verified there			245240	B. WING	i		11/0	02/2018
LAKE WINONA MANOR WINONA, MN 55987 (P4,1)D PHEFK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH BEFLERORY NUST & ERRECEDED BY FLL RESOLATORY OR LSC DENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH DEFLERORY NUST RESOLATION HOLD DEFICIENCY) 0.00000000000000000000000000000000000	NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
Pričejik TAG (EACH ORENTIVE ACTION YOR LSC IDENTIFYING INFORMATION) PRĚTK TAG CEACH ORENTIVE ACTION YOULD E CROSS-REFERENCE TO THE APPROPRIATE COMPLÉTION DERICIENCY F 684 Continued From page 24 during the as tolerated. F 684 F 684 R78's record was reviewed from 8/6/18 through 11/1/18; the record lacked evidence of ongoing edema monitoring. The only edema assessment in the record during that period included the following: -R78's ANNUAL/SCSA Assessment: 10/10/18, EDEMA indicated, no edema was present, had peripheral pulses, and has diagnosis of CHF and received Lasix. Weights stable. F 684 During an observation on 10/29/18, at 2:34 p.m. R78 sat in wheelchair with his eyes closed; R78 legs had Tubular bandages on. R78's legs were edematous; right leg was more swollen than the left when compared. During an observation on 10/31/18, at 7:38 a.m. R78 laid in bed, had gripper socks on. Nursing assistant (NA)-E removed the gripper sock had been was indented. NA-E then put clean socks on. During an interview on 10/29/18, at 2:48 p.m. family member (FM)-A stated R78 had more swelling in both his legs than has had before. FM-A was not sure if R78 received a diuretic medication however, stated he used the "tubi grips" to help with the swelling. FM-A stated R78 had a weight gain since last care conference of at least 3-4 pounds. On 11/1/18, at 9:25 a.m. registered nurse (RN)-A reviewed R78's record and verified there was not documentation of edema and/or not consistent.	LAKE W	INONA MANOR						
 during the as tolerated. R78's record was reviewed from 8/6/18 through 11/1/18; the record lacked evidence of ongoing edema monitoring. The only edema assessment in the record during that period included the following: -R78's ANNUAL/SCSA Assessment: 10/10/18, EDEMA indicated, no edema was present, had peripheral pulses, and has diagnosis of CHF and received Lasix. Weights stable. During an observation on 10/29/18, at 2:34 p.m. R78 sat in wheelchair with his eyes closed: R78 legs had Tubular bandages on. R78's legs were edematous; right leg was more swollen than the left when compared. During an observation on 10/31/18, at 7:38 a.m. R78 laid in bed, had gripper socks on. Nursing assistant (NA)-E removed the gripper socks; the skin above the ankle where the top of the gripper sock had been was indented. NA-E then put clean socks on. During an interview on 10/29/18, at 2:34 p.m. family member (FM)-A stated R78 had more swelling in both his legs than he has had before. FM-A was not sure if R78 received a diuretic medication however, stated he used the "tubi grips" to help with the swelling. FM-A stated R78 had a weight gain since last care conference of at least 3-4 pounds. On 11/1/18, at 9:25 a.m. registered nurse (RN)-A reviewed R78's record and verified there was not documentation of edema and/or not consistent. 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
monitoring and assessment of edema was	F 684	during the as toleral R78's record was re 11/1/18; the record edema monitoring. in the record during following: -R78's ANNUAL/SO EDEMA indicated, r peripheral pulses, a received Lasix. We During an observat R78 sat in wheelch legs had Tubular ba edematous; right le left when compared During an observat R78 laid in bed, had assistant (NA)-E re skin above the ankl sock had been was clean socks on. During an interview family member (FM swelling in both his FM-A was not sure medication howeve grips" to help with th had a weight gain s least 3-4 pounds. On 11/1/18, at 9:25 reviewed R78's rec documentation of e RN-A indicated the	ted. eviewed from 8/6/18 through lacked evidence of ongoing The only edema assessment that period included the CSA Assessment: 10/10/18, no edema was present, had and has diagnosis of CHF and ights stable. ion on 10/29/18, at 2:34 p.m. air with his eyes closed; R78 andages on. R78's legs were g was more swollen than the d. ion on 10/31/18, at 7:38 a.m. d gripper socks on. Nursing moved the gripper socks; the e where the top of the gripper indented. NA-E then put on 10/29/18, at 2:48 p.m. I)-A stated R78 had more legs than he has had before. if R78 received a diuretic r, stated he used the "tubi he swelling. FM-A stated R78 ince last care conference of at a.m. registered nurse (RN)-A ord and verified there was not dema and/or not consistent. overall documentation of	F	584			

If continuation sheet Page 25 of 101

		AND HUMAN SERVICES				FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
		245240	B. WING	G		11/	02/2018
NAME OF I	PROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •	
	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	lacking. RN-A state monitored and door location, extent, and were effective. During an interview 9:34 a.m. R78 sat in with tubular bandag removed the banda trace edema was n R78's right leg had mid-calf. During an interview director of nursing (edema should be d should include loca DON then stated w assessments shoul R7 had been interviat this time R7 was swelling of both low compression wraps the edema, R7 said medication for the s remember. When a monitoring his eder When asked if the down or to put if feet wheelchair. He ther R7 was observed o 12:45 p.m. and legs On 10/31/18, when a.m., 10:50 a.m. an noted to have his feet	d edema should routinely be umentation should include d determination if interventions //observation on 11/1/18, at n his wheelchair in his room ges to both legs. RN-A ages, stated the left leg had ot pitting. RN-A then stated 3+ edema from foot to r on 11/1/18, at 11:20 a.m. (DON) stated, monitoring of one daily; documentation tion and extent of edema. eekly more comprehensive d be done. iewed on 10/29/18, 3:56 p.m. noted to have significant ver legs and noted there were in place. When asked about the though he was on some swelling, but could not asked if the facility was ma he was unable to say. staff encouraged him to lay et up, R7 demonstrated how tup while sitting in his n lowered his feet back down.	F	684			
	A review of R7's pro	ogress notes failed to indicate					

If continuation sheet Page 26 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	RN-F confirmed that edema monitoring/a unable to state how had, but did know h "Ready Wraps" (to according to R7's c the nursing assistant when a nurse would said that "he has be only assess if he has because "this is his assessment is done nurses would rely o on a change in com During an interview director of nursing (monitor edema would chronicity and acute and that "quarterly i asked about R7, giv cardiac and respirat history of hospitalize stated R7 should hat regular basis and m R7's current physicat for Bumex (bumetat reduce fluid retention R7's care plan state volume deficit relate includes nursing as dressing, including	ing of edema. erview on 11/01/18, 9:37 a.m. at R7 did not have regular assessments. RN-F was much edema R7 currently e came to the facility with control swelling) which, are plan, are to be applied by nts daily. When asked about d assess R7's edema, RN-F een pretty stable" so would ad a change in condition home." RN-F said a general e on all resident quarterly, but n nursing assistants to report dition. on 11/01/18, 1:20 p.m. the DON) said that the decision to all be made according to the eness of a resident's condition s not frequent enough." When yen an extensive history of tory issues including a past ation for fluid overload, DON ave edema monitoring on a o less than weekly. an orders included an order nide), a diuretic medication to on. es that R7 is at risk for fluid ed to his ordered diuretic. Also sistants to assist R7 with application of the "Ready	F	\$84			
	Wraps." however, t						

If continuation sheet Page 27 of 101

		AND HUMAN SERVICES				FOI	ED: 04/23/2019 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) [DATE SURVEY
		245240	B. WING	G			11/02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					865 MANKATO AVENUE		
	NONA MANOR				WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	overload. R73's change of co (MDS) an assessm R73 had diagnoses fracture and hypertri identified R73 had s moderately impaire daily living and was medications. R73's physician orc Furosemide (diuret (mg) daily in the mo failure. R73's nutritional ca indicated R73 on 9- gain in 30/180 days Decreased intake, 1 9-30-18. 10-26-18 s with decrease in ed at meals if not eatin R73's fluid volume 10/1/18, included P related to daily use within normal limits dehydration. Appro- (signs and symptor fluids between mea practitioner/medica concerns. Nurse Ai weight, encourage nurse with any sign (constipation, fever	any signs symptoms of fluid andition Minimum Data Set ent dated 10/4/18, identified including Dementia, other ension. The MDS also short term memory problems, d decision making skills for administered diuretic ders dated 10/12/18, included: ic medication) 80 milligrams orning for congestive heart re plan dated 10/26/18, -28-18 had significant weight is caused by edema. 10/2/18, Fall with elbow fracture significant planned weight loss lema. Approach: Offer ensure	F	684			
	increased pulse etc	c.) The care plan did not onitoring and/or management.					

If continuation sheet Page 28 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245240	B. WING	;		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKEW	INONA MANOR				65 MANKATO AVENUE		
				V	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 28	F 6	684			
	and interview with r time. RN-A stated R73 had 3 p mid calves. RN-A s all the way to her kr all the way to her m edema. RN-A state improved. RN-A state improved. RN-A state well, some was wei loss. RN-A stated th charting for the ede congestive heart fa elevate her legs. R feet on the tray tabl R73's physician pro- included, Assessme (congestive heart fa especially given sate extremity edema. H considerably. I doul intake. The pressur would anticipate thi although we do not echocardiograms. I overall beneficial to time. While she doof failure exacerbation furosemide whethe dysfunction. Given be a poor candidate does have known v therefore, there is a has cardiovascular on furosemide 20 m	bgress note dated 8/31/18 ent and Plan: 1. CHF ailure) Probable diagnoses cral edema in addition to lower ler weight is up pretty bt it is from increased oral re is also up significantly. I s is diastolic dysfunction have any previous do not think it would be obtain a cardiogram at this es have congestive heart h, treatment would be r or not it is systolic or diastolic her advanced age she would e for ischemic workup. She rascular calcifications and so a high likelihood that she also calcifications. We will start her ng daily. May need to be daily. She will likely need this					

If continuation sheet Page 29 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED
STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				8	65 MANKATO AVENUE		
	NONA MANOR			V	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 29	F٤	684			
	10/30/18 included, approximately 26 p furosemide at the e potassium supplem per liter) daily. Her l about 2+ from feet clear and no SOB (complaints. Blood p good control. She h furosemide daily sin dosing. Patient is re- stocking or elevation a bit more complain visiting. R73's progress not September and Oc September one pro- included a compref edema that include degree of pitting. In were found that inc assessment of R73 description of the e On 11/01/18, at 1:5 (RN)-C was asked edema and stated t in the notes to help the edema getting v example whether o pitting edema. RN-f other factors such a of shortness of brea-	e practitioner visit note dated CHF the patient has lost ounds since the initiation of end of August. She is also on nent 10 mEq (milliequivalents lower extremity edema is to below the knees. Lings shortness of breath) pressures have been under has been on 80 mg of nee 10/12/18. Continue this esistant to compression g her feet. She does become nt when her daughter is es were reviewed for tober 2018. For the month of ogress noted was found that hensive assessment of R73's d a description of edema and October two progress notes luded a comprehensive d's edema that included a dema and degree of pitting. 6 p.m. registered nurse what should be charted for RN-C stated should chart the the degree of pitting should be determine whether or not it's worse. RN-C stated for r not it is one plus or two plus C stated would also look at as weights or other symptoms ath, all pieces that fit together C stated need to assess all the na and really need to use your					

If continuation sheet Page 30 of 101

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES (X1) PROVIDEROSUPPLIENCIAN DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURV A BUILDING NAME OF PROVIDER OR SUPPLIER LAKE WINONA MANOR STREET ADDRESS, CITY, STATE, ZIP CODE BSG MANKATO AVENUE WINONA, MN 55987 COMPLETER LAKE WINONA MANOR DEFICIENCY MEDICARCES INFORMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP OF F 684 Continued From page 30 assessment skills when assessing the patient. On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated documentation should include if the edema was pitting or non-pitting and a description of the degree of pitting and a description of the degree of pitting and a description of the degree of of pitting and description of the degree of of pitting and description of the edgree of documented in October the included the degree of pitting and description of the edgree of efficiency and procedure on edema were her notes and verified the other notes documented did not include a complete description of edema A policy and procedure on edema monitoring was requested and not provided. F 684	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDEN IDENTIFY IAME OF PROVIDER OR SUPPLIER AKE WINONA MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIFY F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURV COMPLETE B. WING NAME OF PROVIDER OR SUPPLIER 245240 B. WING 11/02/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 855 MANKATO AVENUE WINONA, MN 55987 STREET ADDRESS, CITY, STATE, ZIP CODE 865 MANKATO AVENUE WINONA, MN 55987 ID PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY) ORMED PREFIX (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY) ORMED (EACH DEPICIENCY) F 684 Continued From page 30 assessment skills when assessing the patient. On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated documentation should include if the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes from October for R73 and verified the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema A policy and procedure on edema monitoring was requested and not provided. F 684 <td>ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDEN IDENT IAME OF PROVIDER OR SUPPLIER AKE WINONA MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated</td> <td>3) DATE SURVEY COMPLETED 11/02/2018 (X5) COMPLETION</td>	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDEN IDENT IAME OF PROVIDER OR SUPPLIER AKE WINONA MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	3) DATE SURVEY COMPLETED 11/02/2018 (X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKE WINONA MANOR STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	AKE WINONA MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	(X5) COMPLETION
LAKE WINONA MANOR 865 MANKATO AVENUE WINONA, MN 55987 IXAI) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Common Deficiency F 684 Continued From page 30 assessment skills when assessing the patient. F 684 On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and a description of the degree of dema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided.	AKE WINONA MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	COMPLETION
LAKE WINONA MANOR 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) C/MPI CEACH CORRECTIVE ACTION SUBJECT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C/MPI CEACH CORRECTIVE ACTION SUBJECT ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE ACTION SHOULD BE CROSS-REFERENCE TO THE ACTION SHOULD BE CROSS-REFERENCE TO THE ACTION SHOULD BE CROSS-REFERENCE TO	(X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	COMPLETION
(X4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG D PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPI DP PREFX TAG F 684 Continued From page 30 assessment skills when assessing the patient. F 684 F 684 On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of pitting and a description of the degree of of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided. F 684	(X4) ID PREFIX TAG SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	COMPLETION
PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP DE CONS-REFERENCED TO THE APPROPRIATE COMP DE DEFICIENCY) F 684 Continued From page 30 assessment skills when assessing the patient. F 684 F 684 On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided.	F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have pathy for edema daily. RN-A stated	COMPLETION
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPI DEFICIENCY F 684 Continued From page 30 assessment skills when assessing the patient. F 684 F 684 On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided. A policy and procedure on edema monitoring was	PRÉFIX TAG (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF F 684 Continued From page 30 assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have path for edema daily. RN-A stated	COMPLETION
 assessment skills when assessing the patient. On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided. 	assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have path for edema daily. RN-A stated	
 assessment skills when assessing the patient. On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided. 	assessment skills when ass On 10/31/18, at 4:07 p.m. re (RN)-A stated we have path for edema daily. RN-A stated	
On 10/31/18, at 4:07 p.m. registered nurse (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of edema. At 4:15 p.m. RN-A pulled up progress notes from October for R73 and verified the two notes documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided.	On 10/31/18, at 4:07 p.m. re (RN)-A stated we have path for edema daily. RN-A stated	
 (RN)-A stated we have pathway charting on R73 for edema daily. RN-A stated documentation should include if the edema was pitting or non-pitting and how far the edema extends wherever you would have the edema. RN-A stated she expected the nurse assessing to indicate in the progress notes the degree of pitting and a description of the degree of documented in October the included the degree of pitting and description of the edema were her notes and verified the other notes documented did not include a complete description of edema. A policy and procedure on edema monitoring was requested and not provided. 	(RN)-A stated we have path for edema daily. RN-A stated	
R1's Diagnosis List, dated 11/1/18, included diagnosis of localized edema (dependent bilateral lower extremity edema). R1's current physician treatment orders identified an order dated 10/30/18, Treatment: to left lower extremity (LLE): 1. Cleanse with normal saline or wound cleanser 2. Pat dry with gauze (gentle) 3. Apply no-sting barrier to intact and macerated skin 4. Apply adaptic to small anterior open area and ABD (abdominal pad) 5. Secure with kling and tape, tubigrip and ace 6. Change once daily. Treatment: to right lower extremity (RLE): 1.	 non-pitting and how far the e wherever you would have the stated she expected the numindicate in the progress note pitting and a description of the At 4:15 p.m. RN-A pulled up October for R73 and verified documented in October the of pitting and description of the notes and verified the other did not include a complete description of the requested and not provided. DRESSING CHANGE: R1's Diagnosis List, dated 1 diagnosis of localized edema lower extremity edema). R1's current physician treatman order dated 10/30/18, The extremity (LLE): 1. Cleanse wound cleanser 2. Pat dry was Apply no-sting barrier to inta skin 4. Apply adaptic to sma and ABD (abdominal pad) 5. and tape, tubigrip and ace 6 	
Cleanse with normal saline or wound cleanser 2. Pat dry with gauze (gentle) 3. Apply no-sting barrier to intact and macerated skin 4. Cover weeping areas with maxorb (calcium alginate) and ABD 5. Secure with kling and tape, ace	Pat dry with gauze (gentle) 3	

If continuation sheet Page 31 of 101

PRINTED: 04/23/2019

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED		
		245240	B. WING			11/0	02/2018		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
LAKE WI	NONA MANOR		865 MANKATO AVENUE WINONA, MN 55987						
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
TAG F 684	Continued From pa wraps 6. Change tw under control change During observation registered nurse (R change treatment to removed the old dre and cleansed both Dermal Wound Cle RN-D placed a 4 x 4 skin of the shin area placed an 8 x 10 ab the Vaseline gauze to k to R1's legs. RN-D and placed a 4 x 4 abdominal pads on with Kerlix (cling wr place with tape. RN (compression) over have ace wraps app During interview on director of nursing s to follow R1's physit the lower legs. FOLLOW UP PHYS R34's Diagnosis Lis	ge 31 vice daily, once drainage is ge once daily. on 10/31/18, at 10:31 a.m., N)-D provide a dressing o R1's lower legs. RN-D essings from R1's lower legs lower legs with SAF-Clens AF anser and 4 x 4 gauze pad. 4 Vaseline gauze pad on the a of the right and left leg and odominal pad over the top of . RN-D stated she applied the seep the dressing from sticking lifted up the abdominal pads gauze pad underneath the each leg, wrapped both legs ap) and secured the Kerlix in -D applied a tubigrip each lower leg. R1 refused to oblied to each lower leg. 11/01/18, at 10:04 a.m., the stated she would expect staff cian orders for treatment of SICIAN VISIT: st, dated 11/1/18, included pain unspecified and chronic		684		RATE	DATE		
	identified resident c it as 8 out of 10. Re medication. She ele (emergency room) cardiac issues. Res	press note, dated 10/13/18, complains of neck pain. Rates esident took scheduled pain ected to go to the ER due to concerns of possible sident felt that she was having pressure) elevated, skin							

If continuation sheet Page 32 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF PROVIDER OR SU	PPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOI	र				65 MANKATO AVENUE VINONA, MN 55987		
PREFIX (EACH DEI	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
has a history past and tha want to get if she was feel complained Resident der voiced conce a heart attace (9:45 p.m.) a (oxygen) sat pulse 85, res (10:00 p.m.) to the ER. R34's emerg 10/13/18, ind with physicia R34's record primary phys the ED and I follow up wit recommende During interv stated R34 h after the ED documentati informed R3 DUN stated physician in order sheet of department of	comp of Re t could check ing ho of nech ied ha erns th k. I toc not a construct piration rency co luded n within lacked nin one ed per iew or ad not visit an on R3- 4 was iew or if an of 1 to 2 to ED), to an loo ollow u	laints of neck pain, which she esident had three strokes in the lead to a heart attack. I just and to a heart attack. I just at but not clammy. She pain and shortness of breath. Aving any chest pain. Resident at she thought she was having by residents vitals at 21:45 temperature of 98.1, O2 90% on one liter, BP 212/81, ns 22. BP 197/74 at 22:00 lent decided he wanted to go department (ED) note dated Impression and Plan: follow up n one to two weeks. d documentation R34's vas informed R34 was seen in documentation of a physician e to two weeks as the ED note. 11/01/18, at 10:19 a.m., RN-F been seen by the physician nd R34's record had no 4's primary physician was seen in the ED on 10/13/18. 11/01/18, at 10:27 a.m., the rder to be seen by the weeks was not written on the eturn form the emergency hen there was no order. DON k at the ED progress note, but p with primary physician in one	Fé	584			

If continuation sheet Page 33 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391	
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	C CONSTRUCTION	(X3) DATE	E SURVEY IPLETED	
		245240	B. WING		11/0	02/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) I D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686 SS=D	CFR(s): 483.25(b)(\$483.25(b) Skin Inte \$483.25(b)(1) Press Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that to (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Citation Text for Ta Carey, Lisa Based on observati review, the facility fa treatments as asse healing and preven developing for 1 of stage 4 pressure ul Findings include: The facility's policy included the definiti Stage 1- Non-blanc Intact skin with loca erythema (redness) erythema or change	egrity sure ulcers. rehensive assessment of a must ensure that- es care, consistent with irds of practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced g 0686, Regulation FF11 on, interview and document ailed to provide services and ssed/ordered to promote t new pressure ulcers from 2 residents (R46) who had a	F 686	F686 R46□s Care Plan was reviewed an updated to include specific offloadii cares on 11/30/2018. Updated stat work for Chair Positioning as well a Skin Care policy to define offloadin techniques was updated on 11/30/2 All residents screened for necessit update care plan with offloading techniques. All nursing staff will be trained on offloading standard work 12/11/2018. 8 Random weekly aud be performed by the Nurse Manage Designee x 8 weeks. Results will the brought to the QA/QI Committee for further recommendations.	ng ndard is the g and 2018. y to y to dits will er or be	12/11/18	

Facility ID: 00701

If continuation sheet Page 34 of 101

PRINTED: 04/23/2019

		AND HUMAN SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	Stage 2-Partial-Thick dermis. Partial-thick exposed dermis, pr ulcer. The wound b and may also prese open/ruptured bliste and deeper tissues tissue, slough and of stage should not be associated skin dar associated dermatii (inflammation of sk related skin injury, of tears, burns abrasic Stage 3-Full-thickne skin loss of skin in be visible in the ulc epibole (rolled woun Slough and/or esch obscure the depth of tissue damage varia areas of significant wounds. Undermini Facia, muscle, tend bone are not expose obscures the wound pressure ulcer. Stage 4-Full-thickne exposed or directly tendon, ligament, c Slough and/or esch parts of the wound and/or tunneling off anatomical location	ckness skin loss with exposed kness loss of skin with resenting as a shallow open bed is viable, pink or red, moist ent as an intact or er. Adipose (fat) is not visible are not visible. Granulation eschar are not present. The e used to describe moisture mage including incontinence tis, intertriginous dermatitis in folds), medical adhesive or traumatic wounds (skin	F 68			

If continuation sheet Page 35 of 101
DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245240	B. WING	; <u> </u>		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	R46's Diagnosis Lis dated 11/1/18, inclu behavioral disturban sacral region. A physician visit not had been admitted years of age. R46's quarterly Min assessment dated 9 cognitive skills for d severely impaired, a rejected care during assessment period. was not ambulatory assistance of one s transfers, dressing, required extensive toileting. The MDS frequently incontine incontinent of bowe indicated R46 was a stage 4 pressure pressure reducing on nutrition intervention application of nonsu R46's current physi -Ultram (pain medic day (start date 10/3 -Regular diet with E with all meals (start -Left hip treatment of daily, right hip pad v observe daily and c (start date 9/5/18)	at located on admission form ded dementia without nce, and pressure ulcer of the dated 8/8/18, indicated R46 in June 2018, and was 99 imum Data Set (MDS) 9/6/18, indicated R46's laily decision making were and indicated R46 had g 1 to 3 days of the The MDS also indicated R46 g, required extensive taff member for bed mobility, and personal hygiene, and assistance of two staff for further indicated R46 was int of urine and occasionally I. In addition, the MDS at risk for pressure ulcers, had ulcer and an unstageable e interventions included: device for chair and bed, ns, pressure ulcer care, and urgical dressings. cian orders included: cation) 50 milligrams twice per 1/18) insure (dietary supplement)	F	586			

Facility ID: 00701

If continuation sheet Page 36 of 101

PRINTED: 04/23/2019

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G		E SURVEY PLETED
		245240	B. WING	6		11/(02/2018
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	over eschar and co Kerracel. Secure w tape if needed. Obs same dressing, tho every three days. If registered nurse (R date 9/29/18) -Sacral wound: 1) of cleanser, pat dry. 2 Solution damp to dr cover with 4 x 4 AB change three times R46's undated pres Assessment (CAA) admitted with an ur ulcer that was infect was at risk for press incontinence, poor assistance to move over any one site, a mattress or seat cu "Care Plan" include R46's care plan date was resistive to car to leave resident al and re-approach; if another staff appro care plan dated 100 stage 4 sacral decu to left hip, did not ic that was identified of indicated R46 had i impaired cognition, incontinence, and v Interventions include -Staff to assist resident	ver with Mepilex AG form or ith paper tape or Medipore serve daily, you may use the ugh and change dressing area opens please notify N)/wound care nurse. (start cleanse wound with wound) apply ¼ normal Dakin's ry using kerlix, pack lightly. 3) D. 4) secure with tape. 5) a day (start date 9/7/18). sure ulcer Care Area indicated R46 was newly istageable sacrum pressure ted. The CAA indicated R46 sure ulcers related to nutrition, required staff sufficiently to relieve pressure and required pressure reducing shion. Under the heading id, "Revise current plan". red 10/11/18, indicated R46 es at times and directed staff one for short period of time continued to be resistive have ach. R46's skin impairment 11/18, indicated R46 had a ubitus ulcer and black eschar lentify the lower sacral wound on 9/11/18, and further mpaired skin integrity related impaired mobility, vas resistive to cares.	F	68			

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION G	(X3) DATI	E SURVEY IPLETED
		245240	B. WING	G		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	to avoid having her from side to side if -Nursing to monitor concerns, consult w -Nursing to update practitioner) as nee to skin status. -encourage fluids, o -nursing staff to foll updating wound car as needed with com -Offer snacks betwo Prostat -assist resident with hours and as needed and dry; staff to upo wound noted to be -observe skin for re symptoms of break evaluate, update nu pain to evaluate as -pressure reducing -2 staff with lift shee as needed -assure foam paddi R46's Nursing Assis 10/11/18, included: staff assist for repo continued risk for fu R46's Skin Alteration following document -9/5/18, note includ centimeters (cm) x tunnel 4 cm. Contin changing as directer slough today. Drain	lay on her back repositioning she will tolerate. and chart weekly on all skin with wound nurse as needed. MD/NP (medical doctor/nurse aded with changes or concerns offer lotion to skin ow wound care orders re nurse from clinic or MD/NP neerns een meals, Ensure and h bathroom needs every two ed with goal to keep skin clean date nurse if dressing to sacral soiled to change as needed adness, bruising, or signs and down and update nurse to urse with any verbalizations up needed pad to wheelchair when up et, to move resident up in bed ing intact to left hip. stant Care Plan dated REPOSITIONING: I need 1-2 sitioning every hour due to my urther skin breakdown.	F	68			

If continuation sheet Page 38 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE		
				V	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	repositioning. -9/11/18, note includichange completed assessment a small below sacral wound not include measure nor the new open a -9/12/18, note includication pinkish brown in co- pencil point just belies with care this mornin of pain and fear with repositioning in bedi- -9/14/18, note includication to a cm x 0.5 cm, meas to the other. There circumferentially, m Pt (patient) has pre- continues to be rep with dressings, at the dressing that will be -9/20/18, note includication would is 2.5 cm led deep, serous draination underneath where the cm x 0.3-4 cm. -9/25/18, note includication communicate is 3.5 indicated the wound deteriorate depending	ded: Sacral wound dressing this evening. Upon Il red open area about an inch d was noted. Assessment did ements of the sacral wound trea. ded: Wound on sacrum d from yesterday, drainage lor. New open area size of low the initial ulcer is noted ing. Resident verbalizes a lot h care to wounds and d. ded: The original sacral cm, with tunneling and a second opening that is 0.5 uring 3.5 cm from one wound	F	586			

If continuation sheet Page 39 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATI	E SURVEY PLETED
		245240	B. WING	;		11/(02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	up in her chair. Wo heal when sitting up on bed rest with sid does have two area caused by both pre so side to side repo unless she has a di patient is up in chai activities, will keep any concerns. -9/26/18, Sacral ulo 2.8 cm, tunneling a at 12 o'clock, unabl -10/4/18, note indic was done; moderat drainage. Just belor noted. -10/8/18, note indic measured 1.5 cm x 6 and 12 o'clock po below the larger sat 0.5 cm in diameter. -10/10/18, note indi openings: lowest or and upper opening tunnels from 6 o'clo 11 o'clock is underr -10/17/18, note indi cm length, less that and 12 o'clock but f 1.5 cm. Smaller one cm with 2 cm depth -10/23/18, note incl cm with 1.75 cm de Smaller hole underr 2.5 cm depth. Appli	unds like this do not typically o on it and patients usually are le to side positioning. Patient as on her hips that are problem ssure and hardware migration, ositioning would be difficult ifferent support surface. Since ir and likes to participate in treatment unless staff report are stage IV, 2.8 cm x 1.8 cm x t 6 o'clock 3.3 cm and 2.0 cm le to visualize tunneling. ated sacral wound treatment e amount of bloody yellow w wound bed a pen tip hole ated stage 4 sacral wound c 2.5 cm x 2.8 cm, tunneling at ositions. Second open area cral ulcer measuring less than (did not include a depth). icated sacral region had two ne measured 1.4 cm x 1 cm is 2 cm by 1.2 cm wound ock 4.2 cm. From 6 o'clock to mined about 1.2 cm. icated sacral ulcer less than 2 in 1 cm width, depth 6 o'clock filling in with tissue less than e below tunneling 1 cm x 0.5 in. uded: sacral ulcer 2 cm x 1.5 epth but filling in with tissue. neath 0.75 cm x 1.2 cm with ied dressings as ordered.	F	586			

If continuation sheet Page 40 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245240	B. WING	;		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ge 40	F€	686	3		
	primary physician h empirically with ant infection and new of wound. The note in sacral ulcer had im note referenced are included the left hip measured 2.8 cm b cm. The physician of development of the less than 0.5 cm in visit. During an observat R46 was transferre commode. R46's sa intact. R46 cried of Licensed practical r pain medication alm completed the dress LPN-C indicated R4 with tunneling to a v morning cares were medication assistar assistant (NA)-H, R wheelchair via full b -At 7:53 a.m., R46 v to the dining room f -At 8:07 a.m. R46 v table in the dining room her room, offered to	was wheeled out of her room or breakfast. meal tray was placed in front isted by staff to eat her meal was wheeled to an adjacent					

If continuation sheet Page 41 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING	i		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	not have to use the bottom was shifted because she had b NA- confirmed the offloading (the rem points to prevent tis the sacral region. -At 9:15 a.m. R46 v offered toileting by transferred R46 via commode; the sacr be soiled by watery -At 9:37 a.m. LPN-0 transferred R46 into hands, donned glov dressing which reve were both soiled wi removed gloves, sa gloves, cleansed w hygiene to apply on the lower wound is the bottom of the w wound was not pace upper wound packi bottom of the lower -At 10:15 a.m. R46 -At 10:45 a.m. R46 room sitting up in h -At 10:50 a.m. R46 sitting in wheelchai -At 12:01 p.m. TMA pulled R46 aside an left to the right. How pressure for any len area.	restroom, and verified R46's from the left to the right een leaning more to the left. repositioning was not oving of pressure to pressure sue damage) of pressure to vas wheeled into her room and TMA-A. TMA-A and NA-I full body mechanical lift to the ral dressing was observed to loose stool. C entered the room. NA's o her bed. LPN-C washed ves and removed soiled ealed 2 sacral wounds that th watery loose stool. LPN-C anitized hands, donned new ound, and repeated hand dered treatment. LPN-C stated newer and are conjoined at ound. LPN-C stated the lower ked with anything and the ng could be visualized at the wound. wasted to get out of bed. was observed in the activity er chair. was wheeled to another ated down the hallway. continued to be in the activity	F	586			

Facility ID: 00701

If continuation sheet Page 42 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	65 MANKATO AVENUE		
LAKE W	INONA MANOR			N	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	TMA-D indicated remaking sure the resin their chair; making and/or back far endooffloading was used area. TMA-D stated should be done for During an interview nursing assistant (Norepositioning and oo NA-K then stated if ulcer on their bottor them off the area of NA-K indicated una offloading should of During an interview LPN-C stated resider repositioned/offload tissue re-perfusion. resident should be worse indicated R46 was repositioned/offload in a standing lift which that would be worse During an interview registered nurse (Rassessment notes assessments were residents should be pressure areas for re-perfusion. RN-A attempted and/or or repositioning/offload bottom while in the statement of th	epositioning had to do with sident was positioned correctly on sure they were not leaning bugh. TMA-D then stated d to keep pressure off of the d offloading to reduce pressure about five minutes. (on 10/31/18, at 4:26 p.m. NA)-K used the terms ffloading interchangeably. is omeone had a pressure m then you would have to get f pressure to relieve pressure. awareness of how long ccur for tissue re-perfusion. (on 10/31/18, at 4:33 p.m. ents should be ded for at least 2 minutes for LPN-C indicated ideally the laid down in bed. LPN-C supposed to be ded every hour. LPN-C not like to lay in bed, and used n was harder on her arms, and e. (on 11/1/18, at 9:01 a.m. RN)-A reviewed wound and verified not all wound complete. RN-A indicated e repositioned/offloaded off of at least 1-2 minutes for tissue indicated staff should have	F	586			

If continuation sheet Page 43 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391		
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245240	B. WING	;		11/0	02/2018		
NAME OF	PROVIDER OR SUPPLIER	·		:	STREET ADDRESS, CITY, STATE, ZIP CODE				
LAKE W	INONA MANOR		865 MANKATO AVENUE WINONA, MN 55987						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 686	location. RN-A furth should have re-app nurse, and docume During an interview director of nursing (should be compreh and at a minimum of the NA's moved the while in the wheel of The DON said that better job with repo pressure off the wo should be reposition pressure for 1-2 mi re-perfusion. Facility Skin Care p indicated purpose to prevent pressure of healing of pressure present and to prev additional pressure III. Nursing personn physical exam and determine an indivi- each resident. This protect skin against friction, shearing, m interventions B) end hydration. Update of appropriate protein residents, and fami preventative measu prevention plan who identified E) update	her stated if R46 refused, staff roached her, reported to the ent refusals. on 11/1/18, at 11:04 a.m. the (DON) indicated each wound ensively assessed individually of weekly. DON was informed e resident from side to side thair and called it off loading. the NA's could have done a sitioning/offloading to shift und. DON stated residents ned/offloaded off the area of nutes in order for tissue holicy dated 3/2018, also o: provide care and services to cer development, promote the ulcers/wounds that are rent the development of ulcers/wounds. hel will utilize results of the the skin assessment tools to dualized skin care plan for may include interventions: A) t the effects of pressure, noisture, or bruising courage optimal nutrition and lietary staff to review for supplement C) educate staff, lies on risk factors and ures D) Institute an immediate en potential areas are e care plan, MAR/TAR with	F	686					

If continuation sheet Page 44 of 101

		AND HUMAN SERVICES			FORM	: 04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689 SS=D	completed and doc medical record by t include: A) measure or bruising, noting of condition of surrour signs of infection. V the area should be Treatment of the we implemented. C) A plan and medical st factors to be identifuler. E. Update the to consult. F. If the contact the MD/NP in treatment. V. any resident edu VI. Nursing staff wh receive ulcer educa be instructed on int resident. Facility protocol Sta Repositioning dated purpose to help pre- residents unable to steps included: 1) r repositioned every do so themselves. repositioned in cha side or the other to the resident. 3) Doo and the time. Free of Accident Ha CFR(s): 483.25(d) Accider The facility must er	umented in the electronic he nurse. The assessment will e pressure ulcer, other wound condition of wound bed, nding tissue, and any other Veekly skin assessments of added to the MAR/TAR. B) ound or pressure ulcer being review of the resident's care tatus-any other possible risk ied. D) Identify type of skin e wound care nurse as needed wound has not improved, /Wound specialist for change acation will be documented. ho will be providing care for ation annually. They will also erventions specific for each andard Work Chair d 6/12/14, indicated the event skin breakdown for reposition themselves. Major esidents should be two hours if they are unable to 2) Resident can be ir by moving a pillow to one shift the weight or by reclining cument the change of position azards/Supervision/Devices 1)(2)	F 68	36		12/11/18

Facility ID: 00701

If continuation sheet Page 45 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	2/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa as free of accident I §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa assess for root caus implement intervent injury for 2 of 3 resi for accidents. Findings include: R73's change of co (MDS) an assessm R73 had diagnoses fracture and hyperte identified R73 had s moderately impaire daily living and requised bed mobility, transf personal hygiene. R73's care plan incl traumas Related to fx (fracture) of left ef Goal: Will have no fall. Approaches: As transfers, toileting. hours. Bed in lower to ask for assistance position of recliner of call staff for any assist call light to be hook		F			d nger cy was use will be lits of ekly x	
		agitation and she will unhook					

If continuation sheet Page 46 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G		(X3) DATI	E SURVEY PLETED
		245240	B. WING	Э_			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP COD	E		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 689	and throw on the flor resident's personal checks during night chair no bed, (No a R73 was observed sitting in her recline television; call light R73 was observed sitting in her recline table in front of her, on the paper. The k soft call light was no recliner and she wat R73 was observed sitting in her recline table, with a spoon watching television, her recliner, bell on R72 was observed her recliner, footres call light attached to and was sleeping. R72 was observed her room asleep in positioning, bell on positioned on the flo call light was clippe R73's incident repo resident was found straight out in front against the side of fresh blood noted o	or. Assure non-skid pad in chair, and increased 1-hour when sleeping in personal larms per daughters request). on 10/29/18, 4:12 p.m. to be r in her room watching was attached to her recliner. on 10/31/18, at 6:57 a.m. or in her room, with the tray using a pen and is scribbling bell was on the tray table; the ext to her attached to the as wearing gripper socks. on 10/31/18, at 8:04 a.m. r, feet propped on base of tray in her coffee mug stirring it, call light in reach attached to tray table. on 10/31/18, at 9:54 a.m. in at vas elevated at this time; o recliner, bell on tray table at 11/01/18, at 7:46 a.m. in the recliner, pillows placed for tray table, feet were oor, dressed for the day, and	F	68				

If continuation sheet Page 47 of 101

		AND HUMAN SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				865 MANKATO AVENUE		
LAKE W	INONA MANOR			WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		D BE	(X5) COMPLETION DATE
F 689	laceration noted, bl spontaneously. BP (pulse) 68 Resident staff and gait belt a assessment reveal reluctance to use le appears to be in the (blood pressure) 87 unequal but reactiv sluggish. Unable to hearing deficit. Was result in injury: Yes. scalp, left shoulder harm: moderate ha you fell: unable to r and gripper socks. fall: unsteady gait, i Mental status at tim unable to follow diru unknown. Call butto on at time of fall: No personal alarm. Ha last 30 days: Yes 8 Date of Fall: 9/30/1 R73's post fall inves p.m. Date of incider 7:45 a.m. Day of we injury? Yes, lacerat arm pain which was care as a fx (fractur resident was placed returned with sling Factors: On assess female resident witt congestive heart fa osteoarthritis, mild lung nodules, and h	eeding had stooped (blood pressure) 117/64, P t assisted to feet with three	F 6			

If continuation sheet Page 48 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245240	B. WING	;		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	only see shadows a to her as her hearin ability to always rec limitations is signific does not ask for as call light in which sh un-hooking call ligh room in which she has been more coo (history) of getting u always using her wa noted to come out i as support but is all redirection and staf seen her walking in recent complaints of had recent increase significant lower ex extended to upper to increased complaint Medication status: I in the past week: La Was care plan upda reviewed by RN per implemented at this significant impaired left arm. Resident fa fall: 6. Score followin risk for falls: yes. R73's ED(emergen provider note dated complaint: Residen 0800 this morning. of her head and son Present Illness-Pro- female presents too falling at Lake Wind	ge 48 and you have to be very close og is significantly impaired. Her ognize her needs and cantly impaired and often she sistance and does not like her ne has hx (history) of t and throwing it across the was given a bell to use and perative at times. She has hx up independently and not alker has in the past been n hall using her bedside table most always cooperative with f assistance when they have dependently. She has had no of being dizzy although has e in Lasix secondary to tremity edema, which thigh region and was offering its of lower back and leg pain. Lasix, ultram. New medication asix increased on 9/23/18. ated at time of the fall: Yes- rsonal alarm has been a time d/t (due to) her mobility with inability to use all risk score: Score prior to ng fall: 10. Resident is at high cy department)/urgent care 9/30/18, included chief t is here after falling around Patient has laceration to back re left elbow. History of vider: R73 is 90-year-old day with her daughter after ona Manor. Patient does not es have a history of dementia.	F	689			

If continuation sheet Page 49 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION		E SURVEY IPLETED
		245240	B. WING	<u> </u>		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Patient reports a gr reported by the nur- that is nauseous co- that this occurred a the back of the hea pain in the elbow. F in the left elbow. Sh here. She denies a concerns. Patient is On 10/31/18, at 3:1 (TMA)-A stated R73 her call light cord if stated she does ha she can ring if she an observation, R73 be clipped to her re care planned to not and was observed the recliner attach t On 11/01/18, at 1:0 (RN)-A stated R73 her own; she fell ou elbow. RN-A stated happened she was stated the activity a RN-A stated R73 ha verified the fall door complete investigat include a root cause include staff intervie not include if the ca RN-A stated self-tra the fall, but we do r self-transfer. RN-A into place at the tim alarm, but stated w	ge 49 eat deal of left arm pain. It is se from Lake Winona Manor onsciousness. It is reported t 8 AM. She has laceration to d on the left side as well as Patient is reporting mostly pain he does not recall why she is ny other systemic systems or a incredibly hard of hearing. 1 p.m. trained medication aide 3 would always get agitated by it was hooked to her chair and ve a bell on her tray table that needs us. At 3:16 p.m. during 3's call light was observed to cliner. TMA-A stated it was to eattached to her recliner to remove the call light from he call light to her bed. 7 p.m. registered nurse had a history of getting up on it of bed and fractured her when R73 was asked what unable to respond, RN-A t time of fall was unknown. ad cognitive impairment. RN-A umentation was not a ion of the incident, as it did not e analysis of the fall, did not ews regarding the fall and did are plan was being followed. ansferring was the reason for not know why she was trying to verified the intervention put he of the fall was a personal as no longer being used per RN-A verified without	F	689			

If continuation sheet Page 50 of 101

		AND HUMAN SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	IPLE CONSTRUC			(X3) DATI	E SURVEY IPLETED
		245240	B. WING				11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDR	RESS, CITY, STATE, ZIF	- CODE		
LAKE W	INONA MANOR			865 MANKAT WINONA, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EAC	ROVIDER'S PLAN OF C CH CORRECTIVE ACTIO S-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 689	completing a root c facility would be un- interventions would implemented to mir RN-A verified the ca- not clip the call ligh first came in, she w throw it off. RN-A st follow the care plan recliner. On 11/01/1 through observation recliner and stated R78's Diagnosis Lis diagnoses of histor failure, hypertensio renal disease stage R78's annual Minim 10/11/18 indicated decision making wa MDS also indicated assistance from two mobility, and requir staff for ambulation MDS further indicat since admission or R78's care plan dat Problem: fall risk go as a result of a fall. 10/14/18, included ambulating, transfe comfort levels ever position. Encourage Resident is to be w socks on at all time wheelchair and bec R78 was not attem	ause analysis of the fall the able to determine what be appropriate to be himize the risk of further falls. are plan for R73 included to t to the recliner as when she rould unclip the call light and tated she expected staff to to not have it clipped to her 18, at 1:18 p.m. RN-A verified in call light was clipped to the would reassess. St dated 11/1/18, included y of falls, congestive heart n, diabetes type II, and chronic	F	39				

If continuation sheet Page 51 of 101

		AND HUMAN SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG) BE	(X5) COMPLETION DATE
F 689	place and functioning wheelchair/recliner assisted to bed by 8 request otherwise t and not left in his ro During an observat R78 sat in his whee family member (FM underneath his righ just above his eyeb approximately 2-3 i personal safety alar During an observat R78 sat in his whee present. R78 had p wheelchair. At 9:33 walked into the root R78's progress not p.m. indicated R78 emergency departm significant contusio eye. R78's incident repo the date of fall was the writer of the rep when a loud bang w the hallway lying on on his side, about 1 report further indica activated, did not has the time, and there floor. The report als contusion the size of laceration above his	ng. Dycem no-skid pad in when up. R78 was to be 3:30-9:30 p.m. per family hey ask that he be out by staff bom on night shift. ion on 10/29/18, at 2:30 p.m. elchair in his room next to I)-A. R78 had his eyes closed, t eye was a fading bruise and row was a fading bruise and row was a fading scar nches long. R78 had a rm on his wheelchair. ion on 11/1/18, at 9:32 a.m. elchair in his room with no staff ersonal safety alarm on his a.m. an unidentified NA	F			

If continuation sheet Page 52 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '			(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i		11/(02/2018
NAME OF	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	compress was appl was minor harm ev question, Why do y unable able to resp cognitive deficits. In resident assisted of and into his wheelc into bed at 10:00 p. R78's emergency d 10/13/18, at 10:57 p out of his chair and ground level. The n his head and result laceration around h indicated the lacerat length with a superf sutures. R78 was th facility. R78's Post Fall Ris at 2:16 a.m. indicat was at high risk for dementia with beha incontinence. The a indicated the hallwat dimmed due to the R78's Post Fall Inve 3:20 p.m. identified incident report docu the fall R78 require above his right eye. indicated protective place during the fall charting indicated t Risk Factors: On as	lied, and the degree of harm ent. In response to the report ou think the you fell: resident ond secondary to significant nmediate interventions: ff the floor with the full body lift hair. New interventions: assist m. rounds. lepartment visit note dated p.m. indicated R78 had fallen described as a fall from ote indicated R78 had struck ed in a hematoma and a large is right eye. The note further ation was 6 centimeters in ficial depth that required six hen discharged back to the k Assessment dated 10/14/18, ed R78 had a history of falls, falls, has diagnosis of avioral disturbance, has assessment indicated R78 ay where R78 had fallen was	F	589			

If continuation sheet Page 53 of 101

		AND HUMAN SERVICES					FORM	: 04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	0	(X3) DAT	E SURVEY IPLETED
		245240	B. WING	<u> </u>			11/	02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	P CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ЧX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD	BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 53	F	68	9			
		scular dementia with						
		nce, seizure disorder, and						
		abetes. This resident's antly impaired and his ability to						
	ask for assistance	or recognize his needs is						
		ed in which staff need to						
		eds and very seldom used call inders. His mobility has						
	remained unchange	ed and is able to ambulate with						
		ker although this as well od/behaviors and is noted at						
		gitated and can become						
	physically aggressi	ve and will hit out. Last						
		e fall resident had been noted						
		at times attempting to ed by episodes of sleeping in						
	his wheelchair in w	hich this most likely why staff						
		al chair for comfort although he self -transfer which resulted in						
	· ·	overall status has remained						
	unchanged he has	had not noted changes in						
		o urinary concerns, and up till ad not been offering any						
		had not appeared to be in any						
	discomfort. Second	lary to noted increased						
		Il during the shift care plan has						
		sident to be assisted to be not nily request resident to be						
		8:30-9:00 p.m. otherwise they						
		by staff and not left in his						
		ation report further indicated, in status, had had two falls in						
		nd pattern of falls identified as						
	both occurred durin no pattern to time c	ng his personal chair however, of the falls.						
		eport dated 10/19/18,						
		an unwitnessed fall without n the dining room. The report						

Facility ID: 00701

If continuation sheet Page 54 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245240	B. WING	÷		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	included: writer was alarm going off. We resident on his left what he was doing trying to go home, of The report indicated floor was slippery(), appropriate parties. The incident report and/or ongoing fall R78's Post Fall Inve included the recom report and included and unsteady gait. stable overall with p impaired mobility. T there was not a new staff/resident/or fan reviewed by the reg the fall. The investig R78 as being high last three months a of the falls was indi The Investigation re analysis and/or roo 10/19/18, and furth- identification and/or of interventions relation During an interview family member (FM several falls and has facility initiated the three weeks ago th	s coming off the elevator heard ent into the dining room to find side on the floor. When asked resident stated that he was can you please take me home. d R78 was wearing slippers, report did not indicate why the vital signs, and notifications to did not identify immediate	F	688			

		AND HUMAN SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G		(X3) DAT	E SURVEY IPLETED
		245240	B. WING	G_			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD	BE	(X5) COMPLETION DATE
F 689	indicated R78 had I an alarm on, and th into the hallway with family requested th supervision at night and didn't think stat proximity. During an interview nursing assistant (N for falls. NA-F indic of his room and wit when R78 became self-transfers they t provide distractions During an interview registered nurse (R occurred the nurse charting and compl RN-A then indicated do the fall follow-up talking with the tear in order to evaluate RN-A stated, after t we discussed with f immediate interven his room and lay hi requested times. R report and the fall in confirmed based or not be determined to agitation prior to the behavior analysis. F though R78 was for incontinent brief on assessment or diar RN-A then reviewed	been sitting in his recliner with hen he got up and walked out hout his walker. FM-A stated e staff provide him with more because he moved quickly, f were always in near on 10/31/18, at 11:34 a.m. NA)-F stated R78 was at risk ated staff try to keep R78 out hin view of staff, NA-F stated agitated and attempted ry to ambulate him and/or	F	68				

If continuation sheet Page 56 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i		11/(02/2018
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	on 10/19/18, and in incident report and incomplete. RN-A in lacked identification and the post fall inv comprehensive ass factors, did not inclu- identification of inter team did utilize a for triggers for agitation thing it was talked a investigations were could not be comple During an interview director of nursing (and investigation re- occurred on 10/13/ stated the expectat analysis and docum analysis of why the DON indicated the details of everything investigation and w and details of the te did. Facility policy Cumu 1/2017, included the record is kept in ea medical record to fa patterns of causativ contributed to the fa indicated/directed ti A) Resident is not r a licensed nurse ex- records the blood p B) directed staff to	dicated the both the fall the fall investigation were ndicated the fall incident report n of immediate interventions restigation lacked a sessment of the fall, risk ude a root cause, and lacked rventions. RN-A indicated the bous board to determine n, and when the team noticed about. RN-A further stated fall constant and ongoing and eted all at once. Ton 11/1/18, at 11:20 a.m. (DON) reviewed the incident sports for R78's falls that 18 and on 10/19/18. The DON ion of completed post fall nentation of a root cause fall could have occurred. The documentation should include g they looked at in the hat they did for interventions eam discussion in what they ulative Fall record dated e purpose: A cumulative fall ch resident's electronic acilitate identification of ve factors that may have all. The policy he following: noved unless in jeopardy until camines the resident and	F	589			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED	
		245240	B. WING			11/02/2018		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987			
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689 F 692 SS=G	C) chart fall in ECS checks if applicable assessment x 24 he D) Provider will be for significant injury Leaving a message if no significant injury Leaving a message if no significant injury E) Care plan will be necessary after eac F) Falls discussed wincluding therapy to including therapy to interventions. G) Follow-up recom at that time. H) Overall falls reco quarterly by Quality patters noted. Nutrition/Hydration CFR(s): 483.25(g)(§483.25(g) Assister (Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas comprehensive ass ensure that a reside §483.25(g)(1) Main of nutritional status desirable body weig balance, unless the demonstrates that the	 reporting vital signs, neuro and chart follow-up burs. notified of all falls immediately or change in resident status. afax during clinic office hours ry. reviewed and updated if ch fall. with interdisciplinary team, determine appropriate mendations will be discussed orded will be reviewed Assurance team if specific Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's sessment, the facility must ent- tains acceptable parameters such as usual body weight or ght range and electrolyte resident's clinical condition this is not possible or resident e otherwise; 	C	589			12/11/18	

If continuation sheet Page 58 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) Multi A. Buildin	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245240	B. WING		11/0	02/2018			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE W	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987					
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 692	there is a nutritiona provider orders a th This REQUIREMEN by: Based on observat review, the facility fa comprehensive hyd and monitoring, prio of tube feeding, in of for 1 of 1 resident ((hospitalization. The for R56 who becam sustained acute ren Findings include R56's Diagnosis Lis diagnosis of trauma chronic kidney dise cognitive impairmen added 9/17/18, inclu- hydronephrosis (a s build-up) and const diagnosis of urinary R56's quarterly Min assessment dated of severe cognitive im supervision with ear during the assessm complaints of difficu- weighed 184 pound physician prescribe feeding tube and al- mechanically altere indicated R56 recei	ered a therapeutic diet when I problem and the health care herapeutic diet. NT is not met as evidenced ion, interview and document ailed to complete ration/nutritional assessment or to and/after discontinuation order to prevent dehydration R56) reviewed for facility's failures caused harm ing severely dehydrated and hal failure. At dated 11/1/18, included atic brain injury, dysphagia, ase, cardiomyopathy, mild ht, diabetes type 2. Diagnoses uded left kidney stone, swelling of kidney due to urine ipation. On 9/18/18, a r tract infection was added. imum Data Set (MDS) 5/21/18, indicated R56 had pairment, and required ting. The MDS indicated hent period, R56 had ulty or pain with swallowing, ls, had no weight loss, had a d diet for weight gain, had a so had orders for a d diet. The MDS also ved 51% of total calories and c centimeters (cc) or more of	F 69		onal ed by vere d lists veekly nee.				

If continuation sheet Page 59 of 101

	TMENT OF HEALTH RS FOR MEDICARE						FORM /	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU	ER/CLIA (X2)				(X3) DATE SURVEY COMPLETED	
		245240	B. W	/ING			11/02/2018	
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE	E, ZIP CODE	-	
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCII / MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL PI	ID REF I X TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 692	Continued From pa	ge 59	1	F 692				
	cognitive skills for of severely impaired a for eating. The MDS had no difficulty with weight of 179 poun- prescribed diet for y tube feeding, and re and therapeutic die R56's nutritional ca- identified R56 had I related to dehydrati and had swallowing included: weight will (lbs) and would cor- meet his needs. The directives for staff to intake, not use stra Ensure at 10:00 a.r 2:00 p.m. (8 ounces) care plan did not in R56's hospital discol indicated R56 was 9/13/18. The hospital long-standing histor who just recently has endoscopic gastros 8/24/18. He was ad dehydration, hyperr acute kidney injury. indicated during the diagnosed with urin started on a course R56's nutritional as	weight gain, did not eccived a mechanic t. re plan dated 9/21/1 peen hospitalized or on and urinary tract difficulty. The care I remain above 170 sume adequate inta e care plan further i o ensure adequate inta e care plan further i o ensure adequate for s, and to give stran n. and chocolate En s) for additional calc clude any goal for fl marge summary date admitted to the hosp al note included: R5 ry of traumatic brain ad his percutaneous stomy (PEG) tube re mitted with obvious natremia (high sodiu The discharge sum a hospital course R5 ary tract infection an	g were pervision resident wing, a ysician receive ally altered 8, 9/7/18, infection, plan goals pounds ake to ncluded fluid wberry sure at ries. The uid intake. ed 9/17/18, bital on 56 had injury, moved on m) and mary also 6 was nd was					
FORM CMS-2	567(02-99) Previous Versions	Obsolete E	Event ID: IQ2C11	Fa	acility ID: 00701	If continuation	n sheet Pa	age 60 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245240	B. WING	;		11/02/2018		
NAME OF F	PROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE			
	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	therapy to progress time the diet was m assessment further had increased how breakfast on most of further tube feeding decreased on 6/18/ intake at meals. The decrease in amoun The Osmolite 1.5 w hours per day to run centimeters)/hr (ho p.m., with continued times a day because inadequate. The ass required 2590 cc's indicated a calorie of days. R56's nutritional as indicated fluid intak inadequate as well therefore R56 contri between meals to p also indicated the C held for one week t well and to determine between 185-190 lk lbs. and because fluid water flushes would fluid intake would b The assessment fur monitor his fluid intak was to wean R56 fr for fluids and medic R56's next nutrition 7/23/18, and indicated	to eating by mouth and that at the chanical soft textures. The rindicated R56's oral intake ever, R56 continued to refuse days and may improve with greduction. Tube feeding was '18, to promote increased e note indicated another t of tube feeding would begin. Yould be decreased to three in at 130 cc (cubic ur) from 9:00 p.m. to 11:00 d 400 cc water flushes four se oral intake remained is essment indicated R56 of fluid daily. The note also count would be started for 5 sessment dated 7/5/18, e at meal times was as between meals, and nued to receive water flushes prevent dehydration. The note Dismolite 1.5 feeding would be o see if he continued to eat ne if he could maintain weight bs.; current weight was 189 uid intake was inadequate d continue to be provided and e re-evaluated in one week. rther indicated staff would ake on a daily basis. The goal rom the tube feeding and need cations via the tube. al assessment was dated ted R56 was recently	F	692				
	7/23/18, and indica							

If continuation sheet Page 61 of 101

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i <u> </u>		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	meats, whereas he tube feeding. The a been doing well wit for lunch and dinne breakfast, because assessment also in when he get up in t weight was 197 lbs intake of fluids rem R56's August 2018, Record (MAR) inclu orders: Tube feedir flush daily at 4:00 p start date of 7/30/18 The MAR further in started on 6/29/18, 130 cc's an hour tin discontinued on 8/5 R56's progress not longer receives tub flush daily before su note dated 8/13/18, practitioner was up diet change and a r R56's record lacked fluid intakes were s assessed needs. R56's subsequent r dated 8/14/18, and decreased 8 lbs. in Mighty Shake supp only at dinner. Curr indicated a decreas lbs. The note further	 had previously also had a assessment indicated he had th food intakes from 50-100% or with some refusals for he liked to sleep in late. The adicated R56 received Ensure the morning and his current the however also indicated: "Oral arins inadequate." Medication Administration uded the following physician ang-120 ml (milliliters) manual b.m. to keep tube patent with a 8, and end date of 8/24/18. adicated the previous order that which included Osmolite 1.5, mes three hours was 	Fé	692			

If continuation sheet Page 62 of 101

		AND HUMAN SERVICES				FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245240	B. WING	÷		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	Continued From pa	ge 62	F٤	692	2		
	refused x 2 days, ct 50-100% at dinner, and current textures review weight week include evaluation of R56's progress not continued to be eat and did not have in R56's next nutrition 8/17/18. The asses of the note was due fluctuating. The add the note included: " eating at a supervis plate, gripper mat, g ground up. His fluid receives Might Sha weight is 190-195 II encourage intake o followed monthly." R56's next nutrition indicated a weight of lbs. in one week, co weekly. R56's daily fluid rec reflected the followi 8/20/18: breakfast= refused lunch), dinr (Total 780 cc) 8/21/18: breakfast= dinner=480 cc, dail 8/22/18: breakfast= breakfast), lunch 18 810 cc)	onsumes 75-100% at lunch, no problems with swallowing s provided, no edema. Will dy. The assessment did not of fluid intake. e dated 8/14/18, indicated R56 ing and drinking well at meals dicators of dehydration. al assessment was dated ssment indicated the purpose e to the resident's weight ditional comments section of resident is on a regular diet, is sed table and uses a divided gets his meats chopped or is continually improves. He ke at dinner daily. His goal os. Staff continues to f food and fluids. He will be al note was dated 8/21/18, of 183.2 lbs., decrease of 2.8 ontinue to monitor weight					

Facility ID: 00701

If continuation sheet Page 63 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245240	B. WING	i <u> </u>		11/02/2018		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	 8/24/18: breakfast= 120 cc. (Total 580 cf R56's surgery note reason for visit is to note indicated R56 general diet, and ha by a speech patholo the PEG tube had r months. The note fi pressure was low a communicated to th Manor to do more fi it was stable. R56's progress note was incontinent twid urine with hematuri would encourage fli further hematuria w until 8/28/18. R56's record reflecc intake totals after P continued to lack ev evaluation of daily fi identify current hyd the PEG. 8/25/18: breakfast= dinner=340 cc. (Tot 8/26/18: breakfast= lunch resident does (Total 370 cc) 8/27/18: breakfast= dinner=280 cc. (Tot 	ush 120 cc (Total 970 cc) =180 cc, lunch=160 cc, dinner cc) dated 8/24/18, indicated b have PEG removed. The had been able to eat a ad been thoroughly evaluated ogist. The note also indicated not been used for at least three urther indicated R56's blood and that findings had been he nurse at Lake Winona frequent checks to make sure e dated 8/24/18, indicated R56 ce with dark concentrated a (blood in urine) and staff uids between meals. No vas indicated in progress notes ted the following daily fluid PEG removal; the record vidence of comprehensive fluid intake, and failed to ration needs after removal of =180 cc, lunch=zero, tal 520 cc) =zero resident does not want, s not want, dinner 370 cc's. = 360 cc, lunch=zero, tal 640 cc) =360 cc, lunch=not recorded,	F	692				

If continuation sheet Page 64 of 101

		AND HUMAN SERVICES				FORM): 04/23/2019 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245240	B. WING	;		11	/02/2018
NAME OF PROVIDER OR SUF	PLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE WINONA MANOR					865 MANKATO AVENUE WINONA, MN 55987		
PREFIX (EACH DEF	CIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
 was incontine orange in cold 8/29/18: bread does not wan 150 cc) 8/30/18: bread lunch residen (Total 360 cc) R56's progreet was not feelin symptoms. A p.m. indicated or concentrat well, and had 8/31/18: bread dinner=330. (9/1/18: break refused, noth cc) 9/2/18: break dinner=zero r 9/3/18: break recorded for of 9/4/18: break dinner 300 cc R56's next nu an evaluation indicated a w 8/27/18, weig 175.4 lbs., Th drink Ensure R56's record 	ss not nt twi or. kfast= t, noth kfast= t does ss not g wel progr d no fu ed uri no ind kfast= fast=2 dinner fast=4 efuse fast=3 dinner fast=4 efuse fast=3 dinner fast=4 eight I ht was le note supple	e on 8/28/18, indicated R56 ce with urine that was dark a 150 cc's, lunch=zero resident ning recorded for dinner (Total a zero resident does not want, a not want, dinner=360 cc. e dated 8/30/18, indicated R56 I but demonstrated no outward ess note later that day at 3:35 urther concerns with hematuria ne, continued to drink fluids dicators of dehydration. a zero refused, lunch=160 cc, 490 cc) ero refused, lunch=zero corded for dinner. (Total zero 20 cc, lunch=zero refused, d. (Total 420 cc) 60 cc, lunch=180 cc, nothing . (Total 540 cc) 20 cc, lunch=zero refused,	F	692			

If continuation sheet Page 65 of 101

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES		P		APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1	0	<u>MB NO.</u>	0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245240	B. WING		11/02/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	dinner=420 cc. (Tot 9/7/18: breakfast=4 refused, dinner 460 R56's progress note had cloudy urine wi fluids. R56's record reveal was conducted imm was removed (8/24 assessment indicat requirements was r to 2390 cc, indicatir cc/day, and was at even though, the da between 8/24 throu average liquid cons day. The assessme weight was 175.4 lk 128-161 lbs. Nutrition 1450-2190, protein nutritional supplement further indicated R5 lunch often howeve Ensure, was walkin as much. The asse was a high nutrition reviewed weekly. R56's intake record continued to reflect nutritional assessme assessed fluid intak =2390 cc. On 9/8/18 the reside	10 cc, lunch=190 cc, al of 1220 cc) 20 cc, lunch zero resident cc. (Total 880 cc) e dated 9/7/18, indicated R56 th no burning and to push led no nutritional assessment nediately after the PEG tube /18) until 9/7/18. The 9/7/18,	F 6				

If continuation sheet Page 66 of 101

PRINTED: 04/23/2019

	IMENT OF HEALTH							FORM	04/23/2019 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF	PLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		2452	40	B. WING	i			11/02/2018		
NAME OF I	PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE	, ZIP CODE			
	INONA MANOR					65 MANKATO AVENUE /INONA, MN 55987				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEI MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFI TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD	BE	(X5) COMPLETION DATE	
F 692		ge 66 e dated 9/8/18, ir y swallowing his j that he had been ng recently. A sub ated later that ev me swallowing pi e to get them dow included: breakf o refused, dinners es from 9/9/18, ir st or lunch, and d progress note in slowly like he wa to swallow. 8 included: breakf er=200 cc. (Total es from 9/10/18, breakfast or lunc ter and medication cated at 4:05 p.m er (NP) was upda ds of holding med ot wanting as ma the NP was infor eating his meals, 8 included: break	dicated R56 pills earlier in having a psequent ening R56 lls, however, m. ast=zero =300 cc. dicated R56 id not each dicated he as cfast=240 cc, 630 cc) indicated he h and was pns. The h. on 9/10/18, ated related dications in any snacks as med that he had noted	1	692					
	R56's progress not	es dated 9/11/18,	from a							
FORM CMS-2	567(02-99) Previous Versions		Event ID: IQ2C11	1	Fac	ility ID: 00701	If continuation	n sheet Pa	age 67 of 101	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Provider Visit include verbalizing sore thre difficulty swallowing 4:00 p.m. indicated of attorney and incl and eating well for verbalized sore thre assessment no not R56's nutritional as did not include a co fluid intake. The as weight on 9/10/18, pounds in one weet had been started w swallowing problem evaluated by speec R56's intake 9/12/11 refused, lunch=zero refused. (Total zero R56's progress not had not had a bowe been complaining of suppository was giv large amount of sti assistance. Progres R56's physician vis "He had a feeding to oral intake was mut discontinued. Rece well and has been of discomfort. Nursing	led: "past two days had been oat and had increased at times." A progress note at a discussion with R56's power uded: "although is still drinking meals, past three days has bat at times although upon ed redness." sessment note from 9/11/18, imprehensive evaluation of sessment indicated R56's was 173.4 lbs., down two k. The note indicated Ensure ith meals, but R56 had some is noted so would be h therapist. 8 included: breakfast=zero o refused, dinner=zero	F	592			

If continuation sheet Page 68 of 101

	TIPLE CONSTRUCTION	<u>//B NO. 0938-0391</u>	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILD	DING	(X3) DATE SURVEY COMPLETED	
245240 B. WING		11/02/2018	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR	865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		BE COMPLÉTION	
 F 692 Continued From page 68 F 68 has been in the past." The physical exam indicated no qualifying data for vital signs and measurements, less alert than he previously has been, and had active bowel sounds. The assessment and plan included: "it is apparent that his status is changed considerably since last seen and labs will be ordered to see if there is anything reversible here." R56's intake 9/13/18 included: breakfast=360 cc, lunch=zero refused, dinner= resident was not there. R56's progress note dated 9/13/18, at 1:24 p.m. indicated his physician had called with orders to transfer R56 to the emergency room for intravenous fluids because his lab work reflected "severe dehydration." R56's emergency department visit dated 9/13/18, indicated nursing staff had reported decreased intakes over the past week, labs had been ordered related to weakness, and R56 had been sent to the emergency department for further evaluation. The diagnosis that was given was "dehydration." The notes included: dehydration." Datient had PEG tube removed on 8/24/18, likely unable to keep up fluid needs. The note indicated the patient presented with blood pressures between 99/61 and after intravenous fluids given blood pressure improved to 115/71. The note further indicated the patient reported constipation and had a distended abdomen with no complaints of pain; imaging study would be decided after hospital admission. Physical exam indicated ears, nose, mouth, and throat had dry mucous membranes. Labs on 9/13/18, at 11:05 a.m. 	592		

If continuation sheet Page 69 of 101

		AND HUMAN SERVICES			FORM): 04/23/2019 APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i	11	/02/2018
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 692	 included: sodium of mg/dl (high), and C During an observat R56 laid in bed with assistant (NA)-G st morning cares how bed. NA-G stated s nutritional supplement breakfast. During an observat R56 sat in his whee table. R56 stated ev PEG tube he had b constipation. During an interview registered nurse (R and drinking ok. RN assistants document after each meal. RN if total daily fluid inta not aware of who w of fluid intake in orc could lead to dehyd a decrease in fluid RN-J would encour the documentation interventions attern fluid deficit. RN-J w in urine integrity; RI not call the doctor u symptoms of urinar RN-J also stated it nursing judgement. 	f 149 mEq/L (high), BUN 77 reatinine 2.42 mg/dl (high). ion on 10/31/18, at 7:55 a.m. his eyes closed. Nursing ated she had already provided ever, R56 refused to get out of omebody would take him in a ent and offer him that for ion on 11/1/18, at 7:50 a.m. elchair at the dining room ver since they took out the een struggling with r on 10/31/18, at 4:46 p.m. N)-J stated R56 was eating N-J stated the nursing inted the amount of fluid intake N-J indicated an unawareness ake was assessed and was vas assessing the total amount der to ascertain deficits that tration. RN-J stated if R56 had intake, or was not drinking, age fluids. RN-J further stated should indicate a deficit and pted or used to replace the vas asked about R56's change N-J stated usually they would unless there were three y tract infection. However, would also be dependent on	F	592		

If continuation sheet Page 70 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	;		11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	the PEG tube; the r certain. RN-A state and R56 worked re could be removed. were monitored by the formula when h sustain daily recom RN-A stated the Os held on 7/30/18, with a day until 7/30/18, with a seessment prior to PEG tube removal requirements. RN-A lacked evidence of evaluations to deten the 9/7/18, nutrition identified R56 requi cc. RN-A stated prior R56 had seemed to had been. RN-A state for strict intake and hospitalization; so t weren't accurate. R documentation rela integrity and indicat hematuria document after a couple of da it may have been a physician and just p During an interview nutrition specialist (confirmed neither th dietary supervisor h comprehensive ass	eason for PEG tube was not d R56 had worked with speech ally hard to eat so the PEG RN-A stated R56's intakes dietary and he was weaned off is intakes were sufficient to mended nutritional needs. molite formula started being th 400 cc's flushes three times then the flushes were c's once per day. RN-A ritional assessments and acked evidence of a nutritional o or immediately following the to identify daily fluid intake A also confirmed R56's record daily fluid intake totals and rmine fluid deficits even after al assessment that that ired daily fluid amount of 2390 or to R56's hospitalization, o drink and eat less than he ated R56 did not have an order output monitoring prior to the he amounts entered probably N-A reviewed the ted to R56's change in urine red although there was nted, the symptoms resolved ys with no other symptoms, so ppropriate not to call the bush fluids.	F	692			

If continuation sheet Page 71 of 101
		AND HUMAN SERVICES			FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245240	B. WING		11/	02/2018
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 692	the removal of the I assessment dated intakes as docume nutrition progress n removal of the PEG daily fluid requirem stated she was uns evaluating daily fluid During an interview director of nursing (that nutritional asse completed prior to, the PEG removal, t requirements. The intakes should have evaluated daily. The facility's Hydrat 6/2017, indicated th factors for dehydrat are taken to determ sufficient fluid intak and health status. T following risk factor tube feedings, resid intake, resident lack -Nursing assessme risk is assessed on needed thereafter. provider if dehydrat may be evaluated f symptoms include: tenting of skinCat dehydration should	PEG. The NS said the 9/7/18 did not reflect fluid nted. The NS also verified otes prior to, and after 5 tube, lacked evaluation of ents and deficits. The NS also ure whether nursing was d intakes. on 11/1/18, at 11:42 p.m. (DON) stated the expectation essment should have been and/or immediately following o identify daily fluid DON further stated R56's fluid e been monitored and tion Management policy dated he purpose was: To ensure risk tion are identified and steps nine that a resident has e to maintain proper hydration The policy included the s for dehydration: weight loss, dent dependent on staff for cardiovascular agents, renal refusing fluids, limited fluid king sensation of thirst. ent: A) Residents' dehydration admission, quarterly, and as B) Nursing should update ion is suspected so resident urther. C) Some common thirst, dark urine, headache, re Plans: risk factors for be identified by nursing priate care plan and	F			

		I AND HUMAN SERVICES E & MEDICAID SERVICES			RINTED: 04/23/20 ⁻ FORM APPROVE MB NO: 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245240	B. WING		11/02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE WI	NONA MANOR			365 MANKATO AVENUE WINONA, MN 55987	
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIC
F 692	Continued From pa	age 72	F 692		
	identified nutritiona	on Risk Protocol dated 5/6/17, I risk categories, and included ategories of risk specific for			
	Sufficient Nursing S CFR(s): 483.35(a)		F 725		12/11/18
	the appropriate cor provide nursing an resident safety and practicable physical well-being of each resident assessme and considering the diagnoses of the fa accordance with th at §483.70(e).	ave sufficient nursing staff with mpetencies and skills sets to d related services to assure l attain or maintain the highest al, mental, and psychosocial resident, as determined by ents and individual plans of care e number, acuity and acility's resident population in e facility assessment required	C		
	by sufficient number types of personnel nursing care to all resident care plans (i) Except when wa this section, license	ived under paragraph (e) of ed nurses; and ersonnel, including but not			
	paragraph (e) of th designate a license nurse on each tour	ept when waived under is section, the facility must ed nurse to serve as a charge of duty. NT is not met as evidenced			
		w and record review, the facility		F725	

Facility ID: 00701

If continuation sheet Page 73 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	2/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	failed to ensure suf for the evening shif assistance with per resident's assessed R17, R3, R50, R82 need staff assistant (ADL). Findings include: R8's quarterly, Mini assessment dated cognition and need activities of daily liv R17's annual, MDS cognition and need R3's quarterly, MDS cognition. R50's quarterly, MDS cognition. R50's quarterly, MDS cognition and assist with ADL. R82's quarterly, MD intact cognition and ADL's. R41's quarterly, MD intact cognition. R49's quarterly, MD intact cognition. R49's quarterly, MD intact cognition. R49's quarterly, MD intact cognition.	ficient staffing was available t, in order to provide timely sonal cares according to the d need for 8 of 8 residents (R8, , R1, R49 & R43) assessed to ce with activities of daily living mum Data Set (MDS) and 8/2/18, indicated intact ed extensive assist with	F	725	The staffing guidelines in the facility assessment and staff schedule wer revisited and updated by 11/30/201 residents on LVC. All licensed nurs staff and scheduling staff will be ins on staffing recommendations by 12/11/2018. Random audits of 5 residents weekly will be done by a 3 Worker or designee to determine feedback on staff response. All res will be brought to the QA/QI Comm for further recommendations.	re 8 for sing structed Social sults	

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	65 MANKATO AVENUE		
	NONA MANOR			N	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 74	F 7	'25			
	RESIDENT INTER	VIEWS:					
	10/31/18, at 10:59 a they forget to put yo you have to yell for mad at you for yellin R82, and R41 said reach their call light to them. R41 stated can't reach your cal time because they of waited 20 min, I han couldn't wait anymo didn't want to go in myself and I fell. T months ago. I didn sore for a few days lot of people won't of any good anyways. them turning off our in these meetings a bother complaining a.m. R17 stated, I h and asked, why are Several residents in At 11:07 a.m. 6 of 9 waited over an hour When asked what i wait for a response responded with: R4 stated over an hour hour and 45 minute if anyone had ever so long, R8, R17, F had. R82 stated, "I one answering my	sident council meeting on a.m. R8 stated, sometimes bur call light on you and then help, then they (the staff) get ing for help. R8, R17, R3, R50, that they have been unable to because staff forgot to give it d, "What good will it do if you Il light?" R82 stated, I fell one did not answer my call light, I d to go to the bathroom, I ore, I know I need help, but I my pants, so I tried to go his was during the day about 6 't get hurt bad, but I was sure . At 11:05 a.m. R43 stated, a complain because it doesn't do We have been talking about r call lights for a long time now and it was never fixed, so why ?, it doesn't change. At 11:06 have been yelled at by the staff e you turning on your light? od their heads in agreement. 9 residents stated they have r for call light, they 43, R8, R17, R82, R3 all . R50 stated, wait time was 1 is. At 11:10 p.m. when asked soiled their pants from waiting R3, R50, and R82 all said they felt deserted when I felt no call light when I had to go to id." The worst staffing is					

Facility ID: 00701

If continuation sheet Page 75 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION G		(X3) DATI	E SURVEY PLETED
		245240	B. WING	G			11/0	02/2018
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E		
	IONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	N SHOULD BE COMPLETI		COMPLETION
	their heads in agree R82, R41, R49, and worse on the evenir stated, "We need m staffed." At 11:16 a. concern is when the seems like you sit th you need to get help can get pretty sore. does get awful sore yes in agreement. STAFF INTERVIEW During interview on assistant (NA)-L sta work every fourth w me to stay late on th when we are short s changed a half hou court (LVC), we hav we have 2 aides sch day and evening sh call-in or won't be s aides to work. This doesn't happen as o evening shift. I thin more of a schedulin it happens more on During interview on stated I have worke day shift. Staffing is shift, especially onc school in the fall. I with call lights durin	shift, several residents nodded ement. R8, R17, R3, R50, d R43 said that staffing is ng shift. At 11:13 a.m. R82 nore help, we are too short m. R8 stated, another ey put you on the toilet, it here for an hour, and when p to get off the toilet your butt R82 stated, "Yes your butt !" R17, and R50 all nodded VS: 11/01/18, at 9:13 a.m. nursing ated I mainly work day shift, I reekend and they always ask he weekend. Sometimes staffed and R42 will get r late. I always work lake view ve group 1 and group 2, and heduled for each group for ift. Sometimes an aide will cheduled and we only have 3 is when we are short. This often on day shift, mostly on k our being short on staff is ng issue not a calling in issue, evening shift. 11/01/18, at 9:35 a.m. NA-O ed here 2 years, I work mostly s not good on the evening the the college kids go back to have heard there was issues	F	72				

If continuation sheet Page 76 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245240	B. WING			11/02/2018	
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 725	NA- M stated, I wor every weekend I wor We are usually real weekends. As far a evenings after supplights on at the sam to the bathroom and ideal is to have an e supper until we get help with our call lig have wet their pants to them. I bust my everybody, especia it for very long. I kn lights and we mean right away, but it is bad, I am doing the a problem, sometim sometimes they cal late. So we end up weekends for sure week too. If we wa answered timely we group 1 and group 2 lights after supper t bed. During interview on licensed practical n strictly day shift, we staffing during the o have 1 registered n trained medication a from other staff that call lights being ans they have been bro and this was maybe the call light wait tim	ge 76 k evening shift and almost ork I get asked to stay late. ly short staffed on the as staffing goes, it gets bad on oer, we will have like 8 call the time and they all want to go d then to bed. What would be extra float person on from everybody to bed, this would the problems. I know residents is waiting, I try my best to get butt and I try to get to lly the people I know can't hold now we do turn off the call to get back to the resident of the always possible and I feel best I can. The scheduling is nes an aide is not scheduled, I in, and sometimes they are working an aide is short most and sometimes during the need to get those call lights e should have two aides for 2, with a float to help with call ime until we get everyone to 11/01/18, at 1:40 p.m. urse (LPN)-E stated, I work have no concerns with lay. On evening shift they urse (RN) that floats, then aides and NA's. I have heard t there have been issues with swered during the evening, ught up at resident council, e a couple months ago. I think he is the biggest concern, no ng on the day shift, just the	F7	725			

If continuation sheet Page 77 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	call lights. During interview on maintenance (M)-A	ge 77 11/1/18, at 12:50 p.m. stated, I checked with al crew and at this time we	F 725			
	have no way to run as when they go on off).	11/01/18, at 4:39 p.m. the				
	director of nursing (issue with call lights being provided to the wetting their pants be answered timely, lo because resident di timely and tried to tak knowing she needed voicing complaints a THe DON stated, I treated with dignity	DON) was informed of the a being answered without care he residents in need, residents because call lights are not ing call light wait times, a fall id not get call light answered ake herself to the bathroom d assistance, and residents about being left on the toilet. want all my residents to be and respect.	C			
F 726 SS=D	3/18, indicated the p are sufficient qualifi meet the nursing ca throughout the facil the nurse staff coor (during non busines qualified number of acuity/workload.	Staff	F 726			12/26/18
	the appropriate con	ervices ve sufficient nursing staff with opetencies and skills sets to I related services to assure				

If continuation sheet Page 78 of 101

CENTE	ARTMENT OF HEALTH AND HUMAN SERVICES TERS FOR MEDICARE & MEDICAID SERVICES IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		APPROVED 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 865 MANKATO AVENUE		
LAKE W	INONA MANOR					
(X4) I D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 726	resident safety and practicable physical well-being of each r resident assessmer and considering the diagnoses of the fac accordance with the at §483.70(e). §483.35(a)(3) The f licensed nurses hav and skill sets neces needs, as identified assessments, and of §483.35(a)(4) Provi limited to assessing implementing reside to resident's needs. §483.35(c) Proficient The facility must en to demonstrate com techniques necessa needs, as identified assessments, and of This REQUIREMEN by: Based on observat review, the facility fa knowledge, compet provide care, and re individualized asses that promotes each nursing skills, infect of changes in condi	attain or maintain the highest attain or maintain the highest mental, and psychosocial esident, as determined by nts and individual plans of care number, acuity and cility's resident population in a facility must ensure that ve the specific competencies sary to care for residents' through resident described in the plan of care. ding care includes but is not and ent care plans and responding may of nurse aides. sure that nurse aides are able opetency in skills and ary to care for residents' through resident described in the plan of care. NT is not met as evidenced ion, interview, and record ailed to ensure staff have the encies and skill sets to espond to each resident's seed needs safely in a manner person centered care, basic ion control and identification tion, mental and psychosocial ctice was evident for 2 of 2	F	F726 F726 Standard work for Aseptic Dress Changes was developed on 11/3 for licensed nursing staff. All lice staff will undergo competency te compliance by 12/26/2018. 2 Ri audits of wound or dressing care performed weekly by a Nurse M designee. All results will be brow QA/QI Committee for further recommendations.	30/2018 ensed sting of andom e will be anager or	

Facility ID: 00701

If continuation sheet Page 79 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED
		245240	B. WING		11/02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 726 F 730 SS=E	Finding include: Refer to 880: RN-E hygiene after glove other areas had not and had not cleaned dressing changes. If hygiene after glove scissors for wound Competencies were the competencies were the competencies d wound care. No cor RN-D. During interview on director of nursing of had no competencie Nurse Aide Peform CFR(s): 483.35(d)(7) §483.35(d)(7) Regu The facility must co of every nurse aide months, and must p education based on reviews. In-service requirements of §48 This REQUIREMEN by: Based on interview failed to ensure ann were conducted for E-3, E-4, and E-5) r	E hand not preformed hand removal, had not removed s and soiled gloves touched worn a gown for protection d scissors during wound cares RN-D had not preformed hand removal and had not cleansed care dressing changes. e provided for RN-E, however id not include pressure ulcer mpetencies were provided for 11/01/18, at 3:25 p.m., the confirmed RN-D and RN-E es as noted above. Review-12 hr/yr In-Service 7) llar in-service education. mplete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the	F 72	5	9
	affect all residents i	n the facility who had the eraction with these staff.		mandatory competency labs during t calendar year. All nurse aids and	

Facility ID: 00701

If continuation sheet Page 80 of 101

	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245240	B. WING		11/0	02/2018
NAME OF PROVIDER OR SUPPLI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 employee (E-1) record lacked ar performance revision greater than 10 E2 was hired 8/2 lacked any evide review had beer over two years at E3 was hired 5/2 lacked any evide review had beer over a year ago. E4 was hired 5/2 lacked any evide review had beer eight years ago. E5 was hired 9/2 lacked any evide review had beer eight years ago. E5 was hired 9/2 lacked any evide review had beer wide review had beer review had bee	loyee Roster Report identified was hired 12/6/05, and employee y evidence an annual iew having been completed for rears. 2/16, and employee record nce an annual performance completed since E2 was hired	F 730		18. r or nce :y labs. /Ql	

		& MEDICAID SERVICES	0.00			0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED	
		245240	B. WING		— 11/02/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR		865 MANKATO AVENUE WINONA, MN 55987				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 730	Continued From pa	age 81	F 73	0			
		all employees to verify but don't maintain formal					
	A Performance Rev however was not re Label/Store Drugs CFR(s): 483.45(g)(and Biologicals	F 76			12/11/18	
	Drugs and biologic labeled in accordar professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be nce with currently accepted bles, and include the sory and cautionary e expiration date when	C				
	§483.45(h)(1) In ac Federal laws, the fa biologicals in locke temperature contro	e of Drugs and Biologicals ccordance with State and acility must store all drugs and d compartments under proper ols, and permit only authorized access to the keys.					
	locked, permanent storage of controlle the Comprehensive Control Act of 1976 abuse, except whe package drug distri quantity stored is n be readily detected						
	by: Based on observa	NT is not met as evidenced tion, interview and document ailed to properly secure		F761 Standard work for Medication			

Facility ID: 00701

If continuation sheet Page 82 of 101

		AND HUMAN SERVICES				APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 761	medications for 2 o	f 5 medication carts observed,	F 76	Administration and Medication E		
	were removed from destroyed in a time	e that expired medications n medication storage and ly manner for 5 of 5 carts 3 overflow medication storage		Dates were reviewed on 11/29/1 licensed staff and Trained Medic Assistants will be re-educated o 12/11/2018. On 10/28/18 a revie medication storage areas, includ medication carts, was completed expired medications removed. / audit by the pharmacy consultar	ation n these by ew of ling d and A random	
	Findings include: On 10/31/18, 8:11 a.m. LPN-C was observed to leave a Humalog insulin pen unsecured on top of a medication cart and walk across the hall to give medications to another resident. Following this, LPN-C walked further down the hall to check on a resident to see if she was done with breakfast. At 8:37 a.m. LPN-C returned to the medication cart and prepared the insulin pen for administration. During an interview on 10/31/18, at 11:55 a.m. LPN-C stated that she leaves the insulin pen on top of the cart as a reminder so she "doesn't forget it." LPN-C stated "I thought it was okay because it doesn't have a needle when it's sitting there."		designee will occur monthly on e 3 months for expired meds. 5 observations per week x 5 of me administrations will be done by t Manager or designee to monitor compliance of Expired Medicatio Med Administration standard wo Nurse Manager or designee will full review of medication expirati each unit monthly starting in 12/ results will be brought to the QA Committee for further recommen	each unit x edication he Nurse on and rk. The complete ons for 2018. All /QI		
	was interviewed on expected that all pe administering medi	rector of nursing (DON) who 11/01/18, 1:37 p.m. it was ersons responsible for cations would keep a secure locked area when				
	and the Lakeview C cart a vial of Refres drop) was found wi September/2019 w	0 p.m. while observing LPN-D Court (LC) North medication sh Tears (a moisturizing eye th an expiration date of as found but the label had en on it. LPN-D was unsure as				

If continuation sheet Page 83 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	6		11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	to whether that was open or of when the disposed. LPN-D the overflow storage to bottle LPN-D return been opened Septer According to a docu for various medicat drops are considered opened. This docur medication carts ac page provided. On 10/30/2018, 11: at the second floor hall. Another eye dr drops to treat eleva noted as being in the of the date it was op be okay for six more Manufacturer instru- should be disposed Also, found in the s- -Artificial tears (lubr having been opener -Artificial tears with and no date opener -Ear drops 6.5% (ge wax) with no date o pharmacy 4/15/18. -Lantus insulin (a lo open date but mark to the facility on 9/2 good for 28 to 30 da removed the pen fre- -Milk of Magnesia (figastric upset or cor	the date when the bottle was e eye drop should be een went to the medication get a different bottle. The ed with was marked as having ember 12, 2018. ument listing expiration dates ions used in the facility, all eye ed expired 28 days after being ment is available on all cording to a note written of the 30 a.m. LPN-B was observed medication cart for the south rop, Lumigan 0/01% (eye ted pressure in the eye) was be cart without documentation pen. LPN-B stated, "it should oths after opening." Inction state that the medication of 4 weeks after opening, ame medication cart: iccating eye drops) marked as d 11/9/17 and expired 3/24/18 an expiration date of 8/10/18 d eneric ear drops to soften ear pened but delivered from the and as having been delivered 8/18. LPN-B stated, "it is only ays after opening." LPN-B	F	76			

If continuation sheet Page 84 of 101

DEPAR	FORM	04/23/2019 APPROVED					
		& MEDICAID SERVICES			B NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/	02/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 761	expiration date of 2. -Theragesic (a topic expiration date of 8. -Nystop 100,000 un the skin) with an ex On the same floor k observing TMA-B, a was found that was opened 2/28/18. W used, TMA-B stated months. "At end of surveyors and indic been disposed of be Medication storage the LC unit was exa medication on 11/0 following were disco -Metoclopramide (a expired 8/3/18 -Sumatriptan succir medication)-two bo 10/12/13 -Spironolactone (a c blood-pressure) exp -Senexon (a bowel -Levothyroxine (a th 9/11/18 -Omeprazole (stom 9/15/18 -Losartan (for high 8 /14/18 -Triamcinolone (ste -Hydrophor 42% (m 9/14/18 -Refresh Liquidgel drops)opened 9/12/	 /25/2018. cal arthritis rub) with an /15/15 iits (an anti-fungal powder for piration date of 10/27/18 but the north cart, when a container of Artificial tears marked as having been hen asked if it could still be d, "I think they are good for 6 day, TMA-B found the ated that the eye drops had ecause, "they were expired." for over flow medication on amined with RN-F for expired 1/18, 7:53 a.m. and the overed: medication to treat heartburn) nate (a migraine ttles, expired 5/11/18 and diuretic to treat high bired 10/29/18 stimulant) expired 10/23/18 hyroid medication) expired hach acid reducer) expired blood pressure) expired roid cream) expired 8/18/18 hyroid medicating eye 	F 76				

DEPART		APPROVED					
	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u> MB NO.</u>	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID	SUMMARY STA		ID	•	PROVIDER'S PLAN OF CORRECTION		(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 761	Continued Frame	0 5	- -	704			
F 761		ge 85 otics for gastric problems)	F 7	61			
	expired 10/18	olics for gastric problems)					
	medications, RN-F, unit was asked to e assures expired me RN-said she though supposed to be doin would notice expira administration shou The LC south medic expired medications LPN-C. The followir -Triamcinolone 0.1% triamcinolone 0.1% -Bisac-evac (bowel	g of the above expired nurse manager for the LC xplain the facility process that edications are removed. In the PM shift TMAs were ing this but any nurse who tion dates during medication ild "pull the medications". Cation cart was examined for s on 11/01/18, 9:18 a.m. with ing were discovered: 5 expired 8/14/18 and expired 8/19/18 stimulant suppository) expired	C				
	7/2018 -Ventolin HFAAER the airways) expired	(an inhaler to treat spasms in d 7/13/18	3				
	-hydrocortisone (a s	steroid) expired 8/8/18					
	medication cart was medications on 11/0	sitional Care Unit (TCU) s examined for expired 01/18, 11:11 a.m. with RN-G.					
	The following were	discovered: 1 reducer) expired 8/12/18					
	-Omeprazole 20 mg	g expired 6/17/18					
		bagulant) expired 6/16/18 noisturizing eye drops)					
	-Econazole 1% (and	tifungal cream) expired 5/2018 ntifungal cream) expired					
		er flow store room for the TCU RN-G as well, and the					

If continuation sheet Page 86 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/23/2019 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	G		11/	02/2018	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
TAG F 761	Continued From par following were disco -lpratropium Bromis solution to treat bro - Biotene Dry Mouth 10/16/18 According to an inter 11/01/18, 1:37 p.m. all person administer checking expiration be looking before a are not." A facility provided d Medication Expirati 6/3/2016 includes th before administerin date. Multi-dose infr vaccinations must b date expires and in protocols in book o 30 days, 60 days.). titled Standard Wor updated 6/13/2016 information: Gather the expiration date. be dated and initial 30-60 days depend A facility provided p and dated as havin	ge 86 overed: d & Albuterol (an aerosol nchospasms) expired 9/13/18 n Oral (mouth rinse) expired erview with the DON on she stated an expectation for ering medications to be dates. DON said, "We should dministration, I would say they ocument titled Standard Work: on Checks and last updated he following information: g medication check expiration halers, insulin pens, nitro, be dated when opened. Put itial. Refer to medication in carts for exact amount (i.e. A facility provided document k: Eye Drop Admin. And last includes the following eye drops and be mindful of If a new bottle then it needs to ed (bottles expire between ing on medication. olicy titled Storage-General g been reviewed 6/12 was	1	76	DEFICIENCY)	PRIATE		
	Medications and de ensure their integrit Medications and bio only authorized per drugs and biologica does not include int	les the following information: evices shall be stored to y, stability, and effectiveness. blogicals will be stored so that sonnel have accessAll ils must be secure. The policy formation on who should eas for expired medications.						

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812 SS=E	CFR(s): 483.60(i)(1 §483.60(i) Food sat		F 812	2		12/11/18
	approved or consid- state or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision d from consuming for §483.60(i)(2) - Stor serve food in accord standards for food s This REQUIREMEN by: Based on observat review, the facility fa room trays for the s 5 of 5 room trays do observed during the Findings include: On 10/29/18, at 5:0 (NA)-D started to do second floor. Five r residents in rooms 3 There were no cover included water, coff	 food items obtained directly s, subject to applicable State gulations. bes not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. oes not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional service safety. NT is not met as evidenced ion, interview and document ailed to ensure all items on upper meal were covered for elivered on the second floor e dining observation. 9 p.m. nursing assistant eliver room trays on the oom trays were served to 246, 248, 250, 252 and 243. ers on the beverages, which iee and hot chocolate. There the small dishes of mandarin 		F812 The Lake Winona Manor meal serv policy was updated to include stand tray practices. All LWM Dietary and Nursing staff will be educated on th policy by 12/11/2018. The Dietary Manager or designee will audit 15 m trays weekly x 5 weeks to monitor ff compliance. All results will be brout the QA/QI Committee for further recommendations.	lard d e new oom or	

		AND HUMAN SERVICES			FORM	: 04/23/2019 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 812	Continued From pa	ge 88	F8	12		
F 880 SS=F	the beverages or the oranges had covers the room trays to the floor. NA-D verified covers. On 11/01/18, at 8:5 manager (CDM) stat trays are to be cover on Monday night the were not covered. we had brief meetint talked about the ex- leaves the dining ro- a.m., the CDM verifi- policy to ensure all room trays. The LWM Meal Ser- included, "Resident rooms are able to fi- and have the tray d staff memberb. A- room on a tray must beverages, dessert Infection Prevention CFR(s): 483.80(a)(\$483.80 Infection C The facility must es	n & Control 1)(2)(4)(e)(f)	F 8	80		12/11/18
	designed to provide comfortable enviror	e a safe, sanitary and ment and to help prevent the ransmission of communicable				

Facility ID: 00701

If continuation sheet Page 89 of 101

DEPAR ⁻ CENTEI	FORM APPROVED MB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(a) Infection program. The facility must es and control program a minimum, the follow §483.80(a)(1) A system reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national staff supposed accordin accepted national staff supposed accordin accepted national staff but are not limited t (i) A system of surv possible communic infections before the persons in the facilit (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including the (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplor	n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessment og to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; iom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F 88	30		

If continuation sheet Page 90 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/23/2019 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3)			B) DATE SURVEY COMPLETED	
		245240	B. WING		11/(02/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG) BE	(X5) COMPLETION DATE	
F 880	contact with resider contact will transmit (vi)The hand hygier by staff involved in o §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so a infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review, the facility fa hygiene during a wo 3 residents (R33 an nebulizer equipmen of 1 residents (R37) on-going infection o included comprehen infections that did n analysis of infection within the facility. Th affect all 89 resident	 And the server of the	F	F880 Glucometer standard work updated 11/29/2018. Medication Administra Standard Work updated 11/29/201 Nebulizer standard work reviewed updated on 11/29/2018. Wound C standard Work created 11/30/2018. licensed nursing staff and Trained Medication Aides will be trained on new standard work by 12/11/2018. Random audits of wound or dressi will be performed weekly by the LV Infection Control Nurse or designe observations per week x 5 of medi administration will be done by the I Infection Control Nurse or designe monitor compliance of equipment cleaning and hand hygiene. All res be brought to the QA/QI Committe further recommendations.	ation 8. and are . All the 2 ng care VM e. 5 cation _WM e to ults will		

Facility ID: 00701

If continuation sheet Page 91 of 101

		AND HUMAN SERVICES					FORM	04/23/2019 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	e) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245240	B. WING				11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COI	DE		
LAKE W	INONA MANOR				IANKATO AVENUE ONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 880	R33 was observed receive a pressure by registered nurse hands, applied glow bed (R33 laid on ar had a visible large a sacral wound on the from a sacral wound and left gluteal fold the sacral wound and applied clean glove and removed gloves. Refour strips of carous bed, cut the strips of wound bed) with so the right length, cow foam dressing and applied gloves, plac gluteal wound, appl R33's buttocks and applied gloves and (soaked with a larg- with the same soile Kleenexes, applied removed gloves. Ref tubigrip on R33's le RN-H placed the so tray table, with no b scissors. RN-E rem the tray table and p dressing box on R3 of R33's room and utility room.	In the solution of the solutio	F	380				

If continuation sheet Page 92 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i		11/02/2018	
NAME OF PR	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WIN	ONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
v a H C F F T C S S I V V (F V (F V V (F V V (F V V (F V V (F V V (F V V (F V V (F V V (F)) S S I V V (F) S S S S S S S S S S S S S S S S S S	after leaving R33's had not washed han during the wound ca R34's current care p 10/29/18, Infection s osteomyelitis, MRS. Staphylococcus aur During observations were the only perso PPE) worn. No gov protect clothing fror wound care proced The Centers for Dis nettps://www.cdc.gov ecautions.html read s appropriate to the prevent soiling or co procedures and pat contact with blood, excretions is anticip During interview on RN-G confirmed R3 sacral wound. Whe should wear during for R33's sacral woid drainage is not confishould be followed. staff should gown. R1 was observed o eccive dressing ch extremities by RN-E applied gloves, rem	e start of the wound care and room. RN-E confirmed she nds between glove changes are. plan included problem, dated sacral wound related to A (Methicillin-resistant reus) and cellulitis. s of the wound care gloves onal protective equipment wn was worn by RN-E to n wound secretions during the ure. sease Control (CDC) at //mrsa/healthcare/clinicians/pr I Gowning Wear a gown that e task, to protect skin and ontamination of clothing during tient-care activities when body fluids, secretions, or	F	380			

If continuation sheet Page 93 of 101

		AND HUMAN SERVICES			FORM	04/23/2019 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/(02/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	moderate amount of both LE with wound gloves. RN-D applie Vaseline gauze pace scissors pulled out and applied 4 x 4 g over the Vaseline g Kerlix (cling wrap) a applied tubigrip to the scissors, washed the R1's bathroom, drie scissors back into the hands. During interview on RN-D verified had r glove changes durit both LE. RN-D verified had r glove durit scissors from the science durit scissors from the science durit scissors from the scissors durit scissor durit scissors fr	of green drainage), cleansed d cleanser and removed ed gloves, applied 4 x 4 ls (cut the Vaseline gauze with of uniform pocket) to both LE, auze pad and abdominal pad auze, wrapped both LE with and removed gloves. RN-D both LE. RN-D picked up ne scissor in soapy water in ed the scissors and placed the uniform pocket. RN-D washed 10/31/18, at 10:59 a.m., not washed hands in between ng the dressing change for fied she had not sanitized the e and had cleansed with soap	F				

If continuation sheet Page 94 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245240	B. WING	i		11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	RN-H confirmed the together with moisting RN-H stated we have as part of nursing s trained the equipment after each use, we have once a week. RN-H in July. During interview on stated facility stands equipment after each training was washin but staff should still after each use. The on. The facility Standar 8/9/18, directed was soap and water or w (one time per week SURVEILLANCE: During interview on nursing assistant (N up here on the sout stated she started if sores on her leg fro she was not aware her and another co- they were itching so scabies occurred m we found out reside members went to u	d the same. on 10/31/18, at 9:31 a.m., e nebulizer equipment was ure in the medication cup. d respiratory therapy training kills station and we were ent does not have to be rinsed replace all of the equipment stated I think the training was 10/31/18, at 3:35 p.m., DON ard was to rinse the nebulizer ch use. DON stated the log the machine once a week, be rinsing out the equipment at was what staff were trained d Work sheet, last updated sh mask/medication cup with vinegar, let air dry, 1 X/week) on Wednesdays. 10/31/18, at 10:23 a.m., VA)-A stated we had scabies h hall (second floor). NA-A tching like crazy and had open im the scabies. NA-A stated the residents had scabies, as worker had to find out why b badly. NA-A stated the iid-September. NA-A stated ents had scabies after staff	F	380			

If continuation sheet Page 95 of 101

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
	RS FOR MEDICARE	& MEDICAID SERVICES	1		<u>) MB NO.</u>	0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245240	B. WING		11/	02/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· ·			
	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987				
						()(5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF I X TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 880	Continued From pa	ae 95	F 88	20				
		ugh 9/18 and Antibiotic Use	1 00					
	sheets for 10/18 inc	licated the following:						
	5/18:1 pneumonia, without catheter	2 urinary tract infection (UTI)						
		heter, 1 conjunctivitis, 2						
	wound							
	//18: 1 pneumonia, without catheter	2 UTI with catheter, 1 UTI						
	8/18: 1 upper respir	atory, 2 UTI with catheter, 2						
	UTI without cathete	r, 1 wound 1 UTI with catheter, 1 wound						
		ut catheter, 2 cellulitis, 1						
	presumed bronchiti							
	There was no docu regarding scabies.	mentation from the sheets						
		11/01/18, at 12:59 p.m., RN-I ument analysis of infections, I						
	gather data for infe	ctions. RN-A stated I do not						
		ed education provided for ommunication for infections						
		to prevent the spread of						
	infections. RN-I stat	ted I do not track viruses. RN-I						
		ad scabies in house last she had no documented						
		ng surveillance of the scabies,						
	action taken and ou	itcome. RN-I provided						
		icated 15 residents in the ated with Permethrin topical						
	(works by disrupting	g the function of the neurons						
		mites) for scabies. RN-I						
	stated the medical of staff were offered tr	director was informed and the eatment.						
	The facility policy H	and Hygiene, dated 7/18,						
	indicated VI. Indicat	tions for hand hygiene: Always						
		ne in the following situations. performing invasive						

If continuation sheet Page 96 of 101

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/23/2019 APPROVED 0938-0391
		` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245240	B. WING	э_		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	procedures. Althoug procedures, hand h and after removal is possibility of tears of Between care activi involving different b Foley/IV/wound/trac blood, body fluids of dressings. F. Beford area after touching immediate environr The facility policy S 1/17, indicated II. P (PPE): PPE is worn contact with blood of Wear an impervious prevent soiling or co procedures and pat contact with blood, excretions is anticip The facility policy In undated, indicated a control program: 1. case finding and an assess infection co Prevention is the co identifying potential actions prevent untup process, which esta to respond to outbro cases of infection re Reporting: 1. The ir will analyze and pre- infection control cou	gh gloves are worn for certain ygiene before donning gloves a necessary because of the or holes in the gloves. D. tites on the same patient ody sites (care of ch). E. After contact with r excretions, or wound e exiting the patient's care the patient or the patient's nent. tandard Precautions, dated ersonal Protective Equipment when there is potential for or body fluids. B. Gowns 1. s gown to protect skin and ontamination of clothing during ient-care activities when body fluids, secretion or	F	880			

If continuation sheet Page 97 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL A. BUILD	(X3) DATE	E SURVEY PLETED		
		245240	B. WING			11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	practical nurse (LPI to a medication car medications. LPN-C removed them, but upon removal. LPN medications for R6 cart, computer for c medication contains LPN-C then applied room and administe this, LPN-C again re- removed gloves an- hygiene. LPN-C again re- removed gloves an- hygiene. LPN-C the administration on the R63 received medic when LPN-C was o medication cart after down the halls and injection for R63. L hygiene upon return preparing the insuli cleaned the insulin a needle to the pen- to R63's room where performed and glov administered and L medication cart, rer needle, returned the gloves. LPN-C then hygiene. R63 had a blood su 11:33 a.m. when LF performing a blood the observation, LP glucometer (a mack R63's room where the	N)-C was observed returning t after administering C was wearing gloves and failed to do hand hygiene I-C then proceeded to set up 7, touching the medication documentation, resident ers, and medication cups. I gloves and went to R67's ered medications. Following eturned to the medication cart, d failed to perform hand en documented the	F	380			

If continuation sheet Page 98 of 101

		AND HUMAN SERVICES			FORM	: 04/23/2019 APPROVED . 0938-0391
			TIPLE CONSTRUCTION	(X3) DA1	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/	/02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE
F 880	alcohol and collecter finger with the gluco the soiled glucomer the medication cart barrier between the cart. Following this, did not perform har proper cleaning wip cleansing would ha glucometer remain cart where medicat administration. R30 received media a.m. when LPN-C we medications and er having performed h gloves and adminis R30's gastric tube w Following these tas and left the room to where hand hygien During an interview LPN-C was asked hand hygiene when LPN-C said hand h administering medi different room, to "c about appropriate h hygiene, LPN-C sai remove gloves." LF facility provided free hand washing and a During the same in would clean the glu thoroughly three tim	ed a blood sample from R63's ometer. Then LPN-C carried ter from the room, returned to and set it down without any soiled equipment and the LPN-C removed gloves but nd hygiene. LPN-C stated the bes were not available and ve to wait. The soiled ed on top of the medication ions are prepared for cations on 10/31/18, 11:36 vas observed to prepare R30's net resident's room without hand hygiene. LPN-C applied tered medications and flush without hand hygiene. ks, LPN-C removed gloves o return to the medication cart	C	380		

If continuation sheet Page 99 of 101

		AND HUMAN SERVICES				FORM	04/23/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL A. BU I LD		(X3) DATE	X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) I D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	after, LPN-C picked down the hall with i the nurses' station between the counter while she got the ap LPN-C did not appl glucometer off and counter and surface not cleansed with th During an interview director of nursing of expect general prin be followed by plac surface from contar glucometers should At 11/01/18, 1:30 p. expectations relate medication administ nand hygiene shou medication administ needed, between d A policy for handwar medication administ none provided. A policy for glucom and a document titt and dated 4/6/2017 instructs licensed p medication aides to prior to testing. Fur directs the user to i strip and to clean th Sani-Cloth/purple to and wash hands. A	age 99 d up the glucometer and went t and set it on a counter near without providing a barrier er and the soiled glucometer ppropriate disinfecting wipes. y gloves, but wiped the returned it to the cart. The e of the medication cart were he disinfecting wipes. on 11/01/18, 1:27 p.m. the (DON) stated she would ciples for infection control to ing a barrier to protect a clean mination. DON said that d be cleaned between uses. m. the DON was asked about d to hand hygiene during stration. The DON said that ld be done before and after stration and "in-between as irty to clean" tasks. ashing and glove use during stration was requested and eter cleaning was requested ed Standard Work-Chemstrips ' was supplied. This document practical nurses and trained o wash hands and apply gloves thermore, after testing it mmediately dispose of the test he entire meter with "Super op wipes" then remove gloves in additional document was ility titled, Winona Health	F	380			

If continuation sheet Page 100 of 101

		AND HUMAN SERVICES				FORM	: 04/23/2019 APPROVED . 0938-0391
		(X2) Mul A. Build		(X3) DATE SURVEY COMPLETED			
		245240	B. WING			11/	02/2018
NAME OF I	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAKE W	INONA MANOR				/ANKATO AVENUE ONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	NOVA StatStrip Blo Observation [COMI to perform stated: " Precautions Policy with soap and wate meter should be rea indicates gloves sh testing. After testing the meter should be (Sani-clothe Plus. W then the meter to be to provide the proce glucometer with the use. The document a clean environmer equipment. The Centers for Dis health professional and after direct con contact with blood of	age 100 nod Glucose Meter Direct PETENCY]. The first two steps follow proper Standard Guidelines" and "wash hands or and put on gloves." Then the adied. The competency ould be changed for patient g, the competency directs that e cleaned with "correct wipes Vipes wet not dripping)" and e stored. Both documents fail ess for correctly cleaning the e exception of which wipes to ts do not address maintaining at in response to soiled sease Control recommend s practice hand hygiene before thact with a patient's skin, after or body fluids, after contact hvironment and after glove	F	380			

Facility ID: 00701

If continuation sheet Page 101 of 101

DEPARTMENT OF HEAL	FH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDI	CAID SERVICES
					AND TRANSMITTAL		ID: IQ2C
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00701
1. MEDICARE/MEDICAID PROVID (L1) 245240 2.STATE VENDOR OR MEDICAID (L2) 020945700	 3. NAME AND ADDRESS OF FACILITY (L3) LAKE WINONA MANOR (L4) 865 MANKATO AVENUE (L5) WINONA, MN 			(L6) 55987	 TYPE OF ACTI Initial Termination Validation 	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)	01 Hospital	DVIDER/SUPPLIER CATEGORY pital 05 HHA 09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint	
6. DATE OF SURVEY 12/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	27/2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END 04/30	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO From (a): To (b):	DN	Complianc		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN	6. Scope of S 7. Medical E	Services Limit Director
12.Total Facility Beds 13.Total Certified Beds	110 (L18)110 (L17)	B. Not in Comp	bliance with Progr and/or Applied V		4. /-Day KN (Kulai SN 5. Life Safety Code * Code: A*	 P) 8. Patient Ro 9. Beds/Roon (L12) 	
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 110		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE <u>Maria King, Assistar</u> PA	•	anayei	2/6/2019 BY HCFA RF	(L19) EGIONAI	18. STATE SURVEY AGENCY Kamala Fiske-Downing, OFFICE OR SINGLE S	Enforcement Spe	ecialist 2/6/2019 (L20)
 DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		MPLIANCE WITH HTS ACT:	ł CIVIL	 Statement of Finar Ownership/Contro Both of the Above 	l Interest Disclosure Str	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 02/01/1982	BEGINNING	G DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure 00	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	07-Provi	der Status Change
(L27)	B. Rescind St	uspension Date:	(L44) (L45)			00-Activ	e
28. TERMINATION DATE:	20	. INTERMEDIARY	. ,		30. REMARKS		
20. TERMINITON DATE.	27	03001	of including the second				
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245240

February 7, 2019

Administrator Lake Winona Manor 865 Mankato Avenue Winona, MN 55987

Dear Administrator:

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 26, 2018 the above facility is certified for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

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

DEPARTMENT OF HEALTH AN	D HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAII	O CERTIFIC	ATION A	AND TRANSMITTAL	ID: IQ2C		
	PART I -	TO BE COMPL	ETED BY T	HE STAT	FE SURVEY AGENCY	Facility ID: 00701		
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245240		3. NAME AND AD (L3) LAKE WING				4. TYPE OF ACTION: <u>2 (</u> L8)		
2.STATE VENDOR OR MEDICAID NO.		(L4) 865 MANKATO AVENUE				1. Initial2. Recertification3. Termination4. CHOW		
(L2) 020945700		(L5) WINONA, MN			(L6) 55987	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNE	RSHIP	7. PROVIDER/SUPPLIER CATEGORY			<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Fun Survey After Complaint		
6. DATE OF SURVEY 11/02/2018	. ,	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IIE				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	04/30		
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY		AS:				
From (a):		A. In Complian			And/Or Approved Waivers Of			
To (b):		Program Re Compliance			2. Technical Personnel 6. Scope of Services Limit			
		1 Ac	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director 8. Patient Room Size		
12. Total Facility Beds 11	0 (L18)	1. A	ceptable 100		5. Life Safety Code			
13.Total Certified Beds 11	0 (L17)	X B. Not in Com			5. Life Safety Code			
		Requirements	and/or Applied W	Vaivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
110								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	(IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Lisa Carey, HFE NE II		12	12/14/2018 (L19) Kamala Fiske-Down			Enforcement Specialist 12/28/2018 (L20)		
PART II	- TO BE	COMPLETED B	BY HCFA RE		COFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILITY		20. COM	PLIANCE WITH	I CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2572)		
1. Facility is Eligible to Particip	ate	RIGH	TS ACT:		 Ownership/Control Both of the Above 	bl Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible					5. Bour of the Above			
	(L21)							
22. ORIGINAL DATE 23.	LTC AGREEN	MENT 24	. LTC AGREEM	IENT	26. TERMINATION ACTION	(L30)		
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DAT	Έ	VOLUNTARY 00	INVOLUNTARY		
02/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs			
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)			(L44)			00-Active		
	B. Rescind Si	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
(L	.28)			(L31)				
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE								

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

November 21, 2018

Administrator Lake Winona Manor 865 Mankato Avenue Winona, MN 55987

RE: Project Number S5240030

Dear Administrator:

On November 2, 2018, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

• State Monitoring effective November 26, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy(ies) and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 21, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 21, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 21, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your Lake Winona Manor November 21, 2018 Page 2

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 21, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lake Winona Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 21, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

Lake Winona Manor November 21, 2018 Page 3

DEPARTMENT CONTACT

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

Maria King, RN, APM Licensing and Certification Program Health Regulation Division Minnesota Department of Health Mankato Place 12 Civic Center Plaza, Suite 2105 Mankato, Minnesota 56001-7789 Email: maria.king@state.mn.us Phone: (507) 344-2716 Fax: (507) 344-2723

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, if your ePoC for their 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.
Lake Winona Manor November 21, 2018 Page 4

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

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 2, 2019 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

Lake Winona Manor November 21, 2018 Page 5

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Lake Winona Manor November 21, 2018 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

		AND HUMAN SERVICES			APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		245240	B. WING	1 [,]	/02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
I AKE WI	NONA MANOR			865 MANKATO AVENUE	
				WINONA, MN 55987	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0	
E 035 SS=C	Preparedness Requ October 29, 30, 31, during a recertificat in compliance with Preparedness Requ	aring Plan with Patients	E 03	5	12/11/18
	and maintain an em communication plan State and local laws	y and ICF/IID] must develop nergency preparedness in that complies with Federal, is and must be reviewed and nually.] The communication II of the following:			
	emergency plan, the is appropriate, with families or represent This REQUIREMENT by: Based on interview facility failed to ensu- preparedness plan information the faci- appropriate, with cli representatives. Th 89 residents current their families/represent Findings include: On 10/31/18, at 1:3 policies and proced registered nurse (R	NT is not met as evidenced y and document review, the ure their emergency included a method for sharing lity had determined ents and their families or is had the potential to affect all tly residing in the facility and		E-035 Standard work for family notification of facility emergency plans wi be created on 12/4/2018. The Lake Winona Manor Emergency Prep Policy will be updated to include notification of plan to residents and responsible parties by 12/4/2018. LWM staff will be educated on updates to standard work and policy b 12/11/18. A social worker or designee wi audit perform a monthly audit x 4 months to monitor compliance. Results will be brought to the QA/QI for further recommendations.	i y
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

Electronically Signed

11/30/2018

PRINTED: 12/28/2018

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.

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				55 MANKATO AVENUE INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 035	• • • • • • • • • • • • • • • • • • • •	-	E 0)35			
F 000	their families or rep		FO	000			
	standard survey wa the Minnesota Depa if your facility was ir requirements of 42 Requirements for L The facility's plan of as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	a, 31, November 1 & 2, 2018, a as completed at your facility by artment of Health to determine on compliance with the CFR Part 483, Subpart B, and ong Term Care Facilities. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 557 SS=E	on-site revisit of you validate that substa regulations has bee your verification. Respect, Dignity/Rig	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with ght to have Prsnl Property 2)	F 5	557			12/11/18
	§483.10(e) Respec The resident has a and dignity, includin	right to be treated with respect					
	possessions, includ as space permits, u upon the rights or h residents.	right to retain and use personal ling furnishings, and clothing, unless to do so would infringe lealth and safety of other NT is not met as evidenced					
		tion, interview, and record			F557 Respect/Dignity		

Facility ID: 00701

If continuation sheet Page 2 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING _		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 557	Continued From pareview, the facility fr (R42) was treated i being provided assist Findings include: R42's Face Sheet of admit date of 5/18/ sclerosis (MS), dep R42's quarterly Min assessment, dated intact cognition, red assist with dressing person extensive as transfers. R42's care plan upp problem: I need assist daily living (ADL's) Approach: persona approaches I am m with deviation from sexual assault and me feel vulnerable. they are being prov female care givers care. Problem: I care controlling of others		F 55	DEFICIENCY)	ited on acy on indard in rained om 5 signee	
	taking time to listen allowing me to vent Behavior record ch p.m., indicated, Res staff member telling him in there or even cares with her while	to what I have to say, is helpful and calming. arting dated 10/17/18 at 10:47 sident was rude to the male gother staff she didn't want n want him to be in there to do a aide was in the room. Stated I can't wait for you to go on				

If continuation sheet Page 3 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY IPLETED
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	INONA MANOR			86	65 MANKATO AVENUE		
				W	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 557	Continued From pa	ige 3	F 5	57			
	vacation because y	you bother everyone around with his partner and she was					
	a.m. indicated, resid cares, stating the a towards her. Aide v felt like I was being my shirt, I would as Night aide allowed few minutes later, r	arting dated 10/18/18, at 12:07 dent was upset about her p.m. ides "weren't being friendly was pulling on my shirt and it raped. If I needed help with sk for help, I can do it myself." resident to let out feelings. A resident asked for some hard esident if you need anything to					
	indicated, due to co raped' this writer an nurse) came to talk if she felt threatene responded, "No I ar just grabs and start ready. "Writer aske doing these things a just starts grabbing washcloths ready a goes so fast and I h " Writer paraphra what you are saying without seeing wha does not tell you wh you know what is co that is what he does just do not mesh we the resident say "yo you felt he was gral were being rape? F	dated 10/18/18, at 8:17 a.m. omment of 'felt like being nd charge RN (registered a with resident. Asked resident ad by male caregiver. Resident m not threatened by himhe is doing things and I am not ed resident what she meant by and resident replied that he on my shirt or starts getting and I don't want that yethe have no time to process things ase this reply back stating "So g is that he starts his cares t you need done first or he hat he is doing step by step so oming? Resident said, yes s, you know he and me, we ell. Writer then did question ou reported to my aides that bbing at you and you felt you Resident reply saying "well know he was not going to ay he grab mereminded me					

If continuation sheet Page 4 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 557	of a situation in my the person grab me suggested that due she be ok with fema updated, resident is except in case of el can be used to help During interview on stated, nursing assi- disrespectful toward around 6:30 p.m. I had given me some found out one of my diagnosis may not i what happened was my room to help me the process of takin stated, No, I will ge top on it hit me all v for help if I needed seems like he is alv proceeded to tell hi my shirt, this is the should know it has then backed off and me disrespect!" He pointed towards the and [NA-M] followe in till 9:45 p.m. that [licensed practical r room and said very getting you ready for not, so I don't want being disrespectful her mind up, she w made me feel like I She had been in he	past where I was raped and e similar to this." Writer then to past and situation would ale only care giver. Care Plan s a female only care giver mergency a male care giver o assist resident. 10/30/18, at 9:21 a.m. R42	F	557			

Facility ID: 00701

If continuation sheet Page 5 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING	i		11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	NONA MANOR			-	365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 557	talk to me like that, by both of them. We NA-N helped me int helping me. I am n NA-N, he is on vaca with him. You learn or no way. They ac him, I was just havin the mood to have m next morning [social talked with me, whe he told me they wen NA-N blew it way on telling them that I sa that was not at all w (A)-B] came and as told her it was a PT disorder) thing with shirt. She then told someone to talk to came in and talked R42 stated, "I do no I just want to be treat feel like no one here During phone interv nursing assistant (N find R42 difficult, bu points are valid, sor time getting her poi one of my co-worked on R42's wing. I thi him because he wan night before, and w hold grudges. Anyw and R42 yelled at h go to Mexico! (She	ge 5 pecting her to come in and I feel like I was disrespected ell they both came back and to bed and then NA-M finished ot worried right now about ation, so I haven't had to deal around here that it is their way sted like I was screaming at ng a bad day and I wasn't in ny shirt pulled like that. The I services (SS-B] came in and en I told him what happened re wrong in doing that. I think ut of proportion, I think he was aid he tried to rape me and that I said. Then [administrator ked me what happened and I SD (post traumatic stress n [NA-N] when he grabbed my me they would get me for that. No one else ever to me about it, that was it. of feel like [NA-N] abused me, ated with respect and dignity, I e is supporting me." view on 11/01/18, at 12:39 p.m. IA)-M stated, some people at when she complains her metimes she just has a hard nt across. About 2 weeks ago ers [NA-N] and I were working ink she was kind of mad at s late with her stretches the hen she gets mad she can way's, he had her shirt half on im, get the hell out of here and knew he was going there for ally thought that was	F	557			

Facility ID: 00701

If continuation sheet Page 6 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY IPLETED
		245240	B. WING			11/	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 557	inappropriate. Then not disrespect me li this way, in a very s half on. Then he sa leaving. I thought it me finish putting he suppose [R42] tried through the commo and off, she has an to the trans care un put my shirt half wa stated, I did go back asked if she was re her to bed. [R42] wa and told me she was NA-M verified no ot her about this spect told [registered nurs make sure we char I do think it was dis shirt half on and ha walk out with him, w helping her. During interview on verified the incident during the evening the following morning know NA-M and NA incident and did not I would say leaving off was disrespectfut done. During interview on stated he was not a concerning R42. S was not handled we	age 6 h [NA-N] said to [R42], you will ike that, you will not treat me stern voice and left her shirt aid to me, come on we are was wrong, he should have let er shirt all the way on, I d to make us look bad, going on area with her shirt half on a electric wheelchair and went hit (TCU), telling people, they ay on then left me. NA-M k in there a while later and eady for bed, and we helped vas still very upset with [NA-N] as not going to talk to him. ther staff came and talked to ific incident. The next day we se (RN)-F] and she told us to t this as a behavior, so we did. respectful that [NA-N] left her lf off and demanded me to when I could have finished h 11/01/18, at 2:22 p.m. RN-F t happened on 10/17/18, shift and that she was notified ng. RN-F verified she did A-N were involved in the t interview them. RN-F stated, [R42's] shirt half on and half ul, that should not have been a 11/01/18, at 2:39 p.m. SS-B aware of the whole situation iS-B stated, I feel the situation ell, it is their job to care for the never should have been left	F 5	557			

If continuation sheet Page 7 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING	i		11/0	02/2018
NAME OF F	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 557 F 585 SS=E	dignity, you can't just shirt half on." During interview on verified she went ar morning she was no stated, I will have to before I could say if disrespectfully. A-E mention she left the because she wante During interview on of nursing DON stat about this incident, on that and closed to residents to be treat They (the staff) stru behaviors and we av vulnerable adult and treat her with respe- we have some work Policy requested responded. Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievand §483.10(j) Grievand grievances to the fat that hears grievance	come first. "It does go back to at leave someone with their 11/01/18, at 3:14 p.m. A-B nd talked with R42 the otified of the incident and o interview the staff members this resident was treated 8 further stated, R42 did e room with her shirt half off, d to show them. 11/01/18, at 4:39 p.m. director ted, I was notified right away the administrator followed up the loop on that. I want all my ted with dignity and respect. Iggle with the right tools for her re working at that. "She is a d we have to care for her and ct and dignity, however none)-(4) ces. esident has the right to voice to discrimination or fear of discrimination or		5557			12/26/18
	respect to care and furnished as well as	ances include those with treatment which has been s that which has not been vior of staff and of other					

Facility ID: 00701

If continuation sheet Page 8 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR			-	65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 585	residents, and othe facility stay. §483.10(j)(2) The re facility must make p	r concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in	F 5	585			
		acility must make information evance or complaint available					
	grievance policy to of all grievances reg contained in this pa provider must give a to the resident. The include: (i) Notifying residen postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revie to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvemen Agency and State L program or protectii (ii) Identifying a Grie	acility must establish a ensure the prompt resolution garding the residents' rights tragraph. Upon request, the a copy of the grievance policy e grievance policy must at individually or through ent locations throughout the police grievances orally for in writing; the right to file nously; the contact information ficial with whom a grievance the of the grievance; the right demail) and business phone ble expected time frame for ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman on and advocacy system; evance Official who is rseeing the grievance process,					

If continuation sheet Page 9 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/(02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	receiving and tracki conclusions; leading by the facility; main information associa example, the identif grievances submitte written grievance de coordinating with st necessary in light o (iii) As necessary, ta prevent further pote right while the alleg investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statemen the steps taken to in summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropri accordance with Sta of the residents' rigi or if an outside entit the State Survey Ag Organization, or loc confirms a violation	ng grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by pervices on behalf of the ninistrator of the provider; and	F 5	585			

If continuation sheet Page 10 of 102

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	IG		PLETED	
		245240	B. WING _		11/02/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 585	 (vii) Maintaining evirons and the isonal provident of all grievan 3 years from the isonal decision. This REQUIREMEIT by: Based on observaria review, the facility fimplement a grievaria residents (R8, R17 R25 and R50) review Findings include: During a resident correspondent of the respondent of the respondent of the exception of R1 forms on the doors you fill out the form back to you. R82 stayears and I never the grievance of the stating, "No." a had confused looks they do not respondent heir said this. At 10:40 not always act promised it to the hear (department heads) 	idence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview, and record ailed to communicate and ince process for 9 of 9 , R82, R3, R41, R43, R49, ewed during resident council. ouncil meeting without staff 17, R82, R3, R41, R43, R49, 0/31/18, at 10:30 a.m. when ew how to file a grievance or e official was 8 of 9 residents in they did not know how to file a ne grievance official was, with 18. R18 stated there are paper of the social workers and that and the social worker will get tated, "I have been here for 7 neard of being able to file a asked if the facility follows up esidents were in disagreement and shaking their heads. A few is on their faces, R43 stated, d to our concerns, that's why n't repeat it. Several residents heads in agreement as R43 a.m. R41 stated, no, they do	F 58	F 585 Grievances A policy and form for LWM Grieva was created on 11/30/2018. ALL I staff will be trained on new standa by 12/11/2018. Updated Standard for resident grievance education of by 12/4/2018. All residents and responsible parties will be trained grievance process by 12/26/2018. of resident care conferences will b x 8 weeks by a Social Worker or Designee to determine level of understanding. Results will be bro the QA/QI Committee for further recommendations.	_WM rd work Work reated on Audits ie done		

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING	i		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE WI	INONA MANOR			-	365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 585	Continued From pa certain things in from During interview on unit coordinator (HU grievances are enter medical record), wa paper form. During interview on asked about how a grievance, licensed stated, we do not ha a res had a compla aide would tell me a "I think they have a was unsure and director director of nursing. During interview on registered nurse (R grievances are filed (program in electron used more for famil resident has a com assurance (QA) (ar health record) under official is, I guess it	nge 11 nt of everybody. 10/31/18, at 12:14 p.m. health JC) stated, resident ered into ECS (electronic as not sure if there was a 10/31/18, at 12:16 p.m. when resident would file a l practical nursed (LPN)-C ave paper grievance forms, if int they would tell the aide, the and I would document in ECS, grievance file there." LPN-C ected this surveyor to the 10/31/18, at 2:50 p.m. N)-A stated resident d under logic manager nic health record). This is ly grievance process. If a plaint we chart it in quality nother program in electronic er ECS. I think our grievance depends on what the concern	1	585	DEFICIENCY)	RIATE	DATE
	a resident has a col assistant has no wa a grievance form be access to the qualit nursing assistant or it to the nurse so sh Assurance in ECS to grievance will not go	1 specific grievance official. If ncern I guess the nursing ay to help the resident to fill out ecause they do not have ty assurance in ECS. The r resident would have to report he could put it in quality for investigation. The resident et a letter like the family am not sure why there are two or this.					

Facility ID: 00701

If continuation sheet Page 12 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			• •			(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/0	02/2018
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE WI	NONA MANOR			-	365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	assistant (NA)-L sta grievance form for the been here since Ju During interview on nursing assistant (N resident who had a trained medication they would report it would be down on the the evening shift. I a followed up on. During interview on licensed practical n response to resider aide came to me ar to file a grievance of would ask the charge form." LPN-E was grievance system we charge nurse. During interview on registered nurse (R resident complaint/ resident would have they would put it in sure how a TMA wo If it is a complaint for than nursing we wo manager. This is the receive a letter in re With nursing conce not documented. During interview on	11/01/18, at 9:13 a.m. nursing ated, I don't think there is any the residents to use and I have ne. 11/01/18, at 12:58 p.m. NA)-M stated, If I ever heard a complaint, I would tell my aide (TMA) and then hopefully to the charge nurse which the TCU (trans care unit) for am not sure how they get 11/01/18, at 1:40 p.m. urse (LPN)-E stated in not sfiling a grievance, "If an not told me a resident wanted or complaint, I am not sure, I ge nurse, maybe there is a unable to answer how the vorks and had to ask her 11/01/18, at 1:51 p.m. N)-F stated, as far as a grievance the process is the e to come to licensed staff and QA/incident in ECS. I am not ould file it, I would have to ask. or another department other puld document that in logic ne one where they would esponse to the complaint. rms we follow up verbally, it is	F 5	585			
		tated, I have worked here					

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/02/2018	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585 F 607 SS=D	since 2013, when a process of how a re- who the designated action is taken to re- verified the policy d for grievances. Facility policy, Patie complaint Winona H indicated the purpo- of all negative feedl and to initiate corre- Patients will be info In the event a feedk resolution of the gri person in writing. F should be addresse originates. When n it is entered into the (Logic Manager) as department director (No further plan ide Develop/Implement CFR(s): 483.12(b)(1) §483.12(b)(1) Prohi- neglect, and exploit misappropriation of §483.12(b)(2) Estat to investigate any s §483.12(b)(3) Inclu- paragraph §483.95	asked what the policy or esident files a grievance, and d grievance official is and what esolve the grievance, the DON oes not have a clear process ent/Resident Grievance and /or Health policy, revised 4/18, se: requires prompt reporting back for timely investigation ctive actions as appropriate. Immed of any follow up actions. back is a grievance, the final evance must be given to the Policy: negative feedback ed at the level and at the time it negative feedback is received, e electronic reporting system a soon as possible. The r, manager or supervisor will 0. Intified). t Abuse/Neglect Policies 1)-(3) ility must develop and policies and procedures that: ibit and prevent abuse, tation of residents and f resident property, blish policies and procedures uch allegations, and de training as required at	F	585			12/11/18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245240	B. WING			11/(02/2018	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
LAKE W	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 607	facility failed to ensignative facility failed to ensignative facility failed to ensignative for resident-to-resident procedures for resident at the potential to building. Findings include: Review of The Vulne Plan with a revision policy did not includeres for resident abuse. The Facility flow shalter abuse. During an attention should have known pain or mental angumay have cognitive commit a willful act that if the services (SS Vulnerable Adult Abuinclude a definition SS-A stated, "I gues (referring to definition abuse)." SS-A state was a flow sheet for altercations for staff	ge 14 y and document review, the ure their abuse prohibition res identified a definition of abuse and reporting dent-to-resident abuse. This effect all 89 residents in the erable Adult Abuse Prevention date of 3/18, revealed the le a definition of resident-to eet for Resident-To-Resident 7/2014, included, "Did the in the altercation?" and on of "willful" as the individual itself that he/she knew or could cause physical harm, uish. Even though a resident impairment, he/she could still . The flow chart directed staff did not result in physical tal anguish, the act was not on 10/31/18, at 2:50 p.m.)-A verified by reviewing the puse Prevention Plan, it did not of resident-to resident add at the nurse stations there r resident-to-resident f to follow. SS-A stated the staff if there was no intent to	Fθ	807	F607 Develop and Implement Abuse/Neglect Policies The LWM VA policy was updated w current definition of resident-to-resi abuse on 11/27/2018. All LWM stat be trained on VA Policy by 12/11/20 Random audits of behavior documentation will occur weekly x 8 monitor for compliance to reporting requirements by a Social Worker of designee. Results will be brought to QA/QI Committee for further recommendations.	dent ff will 118. 5 8 to r		

If continuation sheet Page 15 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11/0	02/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From pa not report.	ge 15	F 607	7		
F 676 SS=D	PP dated 11/22/17, as used in this defir individual mush hav individual must hav harm."	ns Manual (SOM) Appendix defined the definition of willful nition of abuse, "means the re acted deliberately, not the e intended to inflict injury or ng (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii)	F 676	5		12/11/18
	assessment of a re- resident's needs an provide the necessa ensure that a reside daily living do not di of the individual's cl	on the comprehensive sident and consistent with the id choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances inical condition demonstrate in was unavoidable. This ensuring that:				
	treatment and servi or her ability to carr	ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)				
		ovide care and services in ragraph (a) for the following				
	§483.24(b)(1) Hygie grooming, and oral	ene -bathing, dressing, care,				
	§483.24(b)(2) Mobi including walking,	lity-transfer and ambulation,				

If continuation sheet Page 16 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	0938-0391 E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAKE W	INONA MANOR				5 MANKATO AVENUE INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	 §483.24(b)(3) Elimit §483.24(b)(4) Dininal §483.24(b)(5) Com (i) Speech, (ii) Language, (iii) Language, (iii) Other functional This REQUIREMEND by: Based on observation observation review, the facility for provided for oral hyresidents (R34), revisedents (R34), revisedents (R34), revisedents (R34), revisedents (R34), revisedents (R34), revisedents, require hygiene and bathing not occur during en R34's care plan, dat assistance with myresidenting I would like it helps myresident require hygiene and bathing of oral hygiene and bathing or occur during en R34's care plan, dat assistance with myresident assist, resident require hygiene and bathing of oral hygiene and bathing or occur during en R34's care plan, dat assistance with myresident assist, resident require hathing: dependent with set 	nation-toileting, ng-eating, including meals and munication, including l communication systems. NT is not met as evidenced tion, interview and document ailed to ensure cares were rgiene and bathing for 1 of 5 viewed for activities of daily inimum Data Set (MDS), dated 34 had moderate cognitive ed one assist with personal g and activity of bathing did tire period. ted 9/21/18, included I need ADLs and approaches ne set up assist and for to try a whirlpool bath to see if stant care sheet included with one person physical uest tub bath one time a week ral care: upper full set, four e bottom. Grooming:	F 6	76	F676 ADLS-Care plans and NA tas were reviewed and updated for R34 11/29/2018. R78 no longer resides facility. Standard work for oral care the Resident S Personal Appearan Hygiene Policy were reviewed and updated on 11/29/2018. All nursing will be trained on new standard wor 12/11/2018. 5 random audits of bo care and bathing records will be performed weekly x 5 by the Nurse Manager or Designee. Results will brought to the QA/QI Committee fo further recommendations	4 on at this e and nce and g staff rk by th oral be	

Facility ID: 00701

If continuation sheet Page 17 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245240	B. WING _			11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 676	stated they do not of anymore. I am was room. I only get a s the scoop is. I have and that was in the During interview on stated I do not alwa teeth. I do not know not ask. They offer time I had my teeth ago. During observation R34 laid in bed dres stated my upper de night. When asked mouth had been br R34 stated no, I she at the time I was dr rush when they con R34's record identifi was documented for assistants: 9/10/18 bath given and 10/8 shower given. During interview on nursing assistant (N R34 with a.m. cares offered or brushed teeth when providin I gave R34 her upp or brush R34's natu During interview on director of nursing (offer me a bath or shower hed up in the bathroom in my crub down. I do not know what a had my hair washed one time shower that I had once. 10/29/18, at 3:22 p.m. R34 ays get help with brushing my v if that is my fault or not. I do once in a blue moon. The last brushed was a couple months on 10/31/18, at 8:26 a.m., ssed eating breakfast. R34 enture plate was cleaned last if her four natural teeth in her ushed this morning with cares, ould have had them brushed ressed. Everything is in such a ne in to help you get dressed. fied the following information or bathing by the nursing tub bath given, 9/17/18 bed 8/18 hair shampooed and no 10/31/18, at 9:19 a.m., NA)-B stated she had assisted s. When asked if she had R34's four bottom natural ng morning cares, NA-B stated ber denture, but I did not offer		76			

If continuation sheet Page 18 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676 F 677 SS=D	and evening cares, request. DON state hygiene to be comp During interview on stated R34 received and the nursing ass of the bath under the the computer syster During interview on DON reviewed R34 above three times of documented. DON documentation of a been completed for have missed chartin would not expect to documentation not DON stated if the re- would expect staff the The facility policy C Conferences, dated multidisciplinary app each resident's care the resident's care the resident's care the resident's optim psychosocial, functi- status. ADL Care Provided CFR(s): 483.24(a)(2) A res- out activities of daily services to maintain personal and oral h	be completed with morning anytime needed and at of she would expect oral oleted every a.m. or offered. 11/01/18, at 7:53 a.m., NA-C d a bath on Monday evenings sistant's document completion ne nursing assistant charting in m. 11/01/18, at 10:09 a.m., the 's record and confirmed the of bathing having been stated there was no other ny other times bathing had R34. DON stated staff may ng a bath for R34, but she o see that many gaps of being completed for bathing. esident had refused, she to document the refusal. Care Plans and Care d 4/16, indicated a proach is used to individualize e plan to achieve and maintain nal physical, communicative, ional, spiritual and emotional for Dependent Residents 2) sident who is unable to carry y living receives the necessary n good nutrition, grooming, and	F6				12/11/18
		NI IS NOT MET AS EVIDENCED					

Facility ID: 00701

If continuation sheet Page 19 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	review the facility fa assistance for 1 of a activities of daily live Findings include R78's Diagnoses Lid diagnoses of malige constipation, and cl R78's annual Minim 10/11/18, indicated decision making we MDS further indicat assistance from two extensive assistance The MDS also indic incontinent of bladd a toileting program. R78's urinary incon Assessment (CAA) did not include a da indicated R78 requi was taking diuretic incontinence and at to overflow incontin R78 had diabetes, I stress incontinence indicated, "revise cu R78's self-care defi plan dated 10/3/18, assist depending or every two hours and further directed staf	ion, interview, and document iled to ensure timely toileting 5 residents (R78) reviewed for ing. st dated 11/1/18, included nant neoplasm of bladder, nronic renal disease stage 4. num Data Set (MDS) dated R78 cognitive skills for daily ere severely impaired. The ed R78 required extensive of o staff for transfer and se from one staff for toileting. stated R78 was frequently ler and bowel and was not on tinence Care Area that was printed on 11/1/18, te of completion. The CAA red assistance with toileting, medication that caused urge nticholinergic's that made lead ence. The further indicated oladder cancer, and had with urgency. The CAA also	F 6	77	F677 R78□s is no longer a resident at th facility. Toileting standard work wa created on 11/30/2018. All nursing will be trained on the toileting stand work by 12/11/2018. 5 Random au weekly of toileting completion will o 6 weeks by the Nurse Manager or designee. Results will be brought to QA/QI Committee for further recommendations.	s staff lard dits ccur x	

If continuation sheet Page 20 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245240	B. WING			11/	02/2018
NAME OF	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	risk for impaired sk incontinence and di and dry and to appl incontinent episode R78's progress note Resident is totally di toileting needs. He will have bowel moving gets him there in tim he needs to use the increasingly anxiou movement and that During an observat R78 laid in bed with assistant (NA)-E incone assist or two as mood was in the me to wake R78 up and and blankets. The tip pad and fitted botto saturated with urine gown were also sat entered the room to resistive to get out of R78's gown and rep sheet with a fresh of socks on R78's fee neither NAs offered nor did the attempt brief or linen. During an interview NA-E stated she att however, he was no	4/18, indicated R78 was at in integrity related to rected staff to keep skin clean y barrier cream after any e dated 10/16/18, included: lependent on staff for all is incontinent of both, but he vements in the toilet if staff ne. He doesn't tell staff when e toilet, but becomes s when needs to have a bowel is a cue for the staff. ion on 10/31/18, at 7:38 a.m. his eyes closed. Nursing dicated sometimes R78 was a ssist depending on what his orning. NA-E attempted gently d folded down the top sheet op sheet, mattress protector m sheet were noted to be a. R78's incontinent brief and urated. At 7:47 a.m. NA-F o assist NA-E. R78 became of bed. While NA-F changed blaced the urine saturated top sheet, NA-E put new t. During the observation to take R78 to the bathroom to offer or change the soiled on 10/31/18, at 8:52 a.m. tempted to get R78 up again, ot ready to get up. NA-E she hy cares, however, the nurse	F	577			

If continuation sheet Page 21 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR			-	865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 21	F	677			
	NA-E knocked on F laid in bed with his of NA-E stated R78 co R78 if he wanted to not respond. NA-E checking R78's line the restroom. During an observat registered nurse (R room. R78 was agr and allowed NA-F a morning cares. R78 pad, and fitted botto urine.	ion on 10/31/18, at 10:01 a.m. R78's room and entered. R78 eyes closed and snoring. ould sleep all day. NA-E asked o get up and get ready, R78 did then left R78's room without en or offering to take R78 to ion on 10/31/18, at 11:34 a.m. N)-C and NA-F entered R78's eeable to get up out of bed and NA-G to assist with B's brief, mattress protector om sheet were saturated with					
	NA-F stated she ha offered and/or chec and linen as she ha arriving in the room she would have kno during the first atter would have asked a linen. NA-F stated t attempted to be cha been offered toiletin changed. During an interview registered nurse (R supposed to be toile was in bed he was changed every two sometimes R78 dis	r on 10/31/18, at 11:43 a.m. ad thought the other NA had sked and changed R78's brief ad been in there prior to her that morning. NA-F stated if own that was not completed mpt to get him out of bed, she and/or changed the soiled the linen should been anged and R78 should have ng and/or checked and r on 11/1/18, at 8:31 a.m. N)-A stated R78 was eted every two hours and if he supposed to be checked and hours. RN-A indicated played aggressive behaviors key, if R78 had behaviors the r staff to leave and					

Facility ID: 00701

If continuation sheet Page 22 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677 F 684 SS=E	re-approach until co could not tell staff w bathroom. RN-A sta change and/or offer multiple times then should have been n During an interview director of nursing (offered toileting or co per the care plan. D was incontinent sta another hour to re-a garments and linen refusals of care to t with another interve Policy relating to inc requested and not r Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a rea that residents receiv accordance with pro practice, the compre- care plan, and the r This REQUIREMEN by: Based on observat review, the facility fa assessment/monito	 boperative. RN-A stated R78 when he needed to use the ated it was expected staff toileting and if R78 refused the nurse or clinical manager nade aware. on 11/1/18, at 11:20 a.m. DON) stated staff should have checked and changed R78 as DON further indicated if R78 ff should not have waited approach to remove the soiled and should have reported the he nurse in order to come up ention. continence/toileting was received. 	F 6		F684 Care plans for R7 and R73 were rev and updated to include edema moni instructions by 11/30/18 . R78 is no a resident at the facility. New standa	viewed itoring longer	12/11/18

Facility ID: 00701

If continuation sheet Page 23 of 102

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245240 B. WING 11/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **865 MANKATO AVENUE** LAKE WINONA MANOR **WINONA, MN 55987** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 684 Continued From page 23 F 684 complications. Also the facility failed to ensure a work was developed on Edema dressing change was implemented as written per monitoring and Aseptic Dressing Changes the physician orders for 1 of 1 resident (R1) and on 11/30/18. All residents screened for failed to ensure a follow-up physician visit was necessity of edema monitoring and care completed for 1 of 1 resident (R34) following a plans updated accordingly. All licensed visit to the emergency room. staff will be trained on new standard work and policy updates by 12/11/2018. Weekly audits of 5 residents appropriate Findings include: for edema checks will be performed by EDEMA MONITORING: the Nurse Manager or designee x 6 weeks. Results will be brought to the R78's Diagnosis List dated 11/1/18, included QA/QI Committee for further diagnosis of congestive heart failure, recommendations. hyperkalemia (high potassium), chronic kidney Provider Notification standard work was disease stage 4, and vascular dementia. updated on 11/30/2018 to include actions related to discharge provider visit recommendations. All Licensed Nursing R78's annual Minimum Data Set (MDS) an assessment, dated 10/11/18, indicated R78's staff and Health Unit Coordinators will be cognitive skills for daily decision making was educated on standard work by severely impaired, identified the diagnosis of 12/11/2018. 2 Random audits of standard congestive heart failure (CHF), and received work will be performed by a Health Unit diuretic medications during all days of the Coordinator or designee weekly x 6 weeks. Results will be brought to the assessment period. QA/QI Committee for further R78's physician orders dated 11/1/18, included: recommendations. -Furosemide (diuretic medication) 40 milligrams (mg) twice per day (start date 7/17/18). -Tubular bandage/Ted hose (compression stockings) to both lower extremities on during the day and off at night (start date 10/4/18) R78's care plan dated 11/1/18, did not identify diagnosis of CHF nor goals for treatment and management. The skin integrity care plan dated 9/15/18, directed staff to observe skin with cares for any redness signs and symptoms of skin breakdown and update nurse to evaluate as needed. Ted stockings on in the morning and off at bed time, encourage resident to elevate legs

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 24 of 102

PRINTED: 12/28/2018

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	11/1/18; the record edema monitoring. in the record during following: -R78's ANNUAL/SC EDEMA indicated, r peripheral pulses, a received Lasix. We During an observat R78 sat in wheelcha legs had Tubular ba edematous; right le left when compared During an observat R78 laid in bed, had assistant (NA)-E re skin above the ankl sock had been was clean socks on. During an interview family member (FM swelling in both his FM-A was not sure medication howeve grips" to help with th had a weight gain s least 3-4 pounds. On 11/1/18, at 9:25	ted. eviewed from 8/6/18 through lacked evidence of ongoing The only edema assessment that period included the CSA Assessment: 10/10/18, no edema was present, had and has diagnosis of CHF and ights stable. ion on 10/29/18, at 2:34 p.m. air with his eyes closed; R78 andages on. R78's legs were g was more swollen than the d. ion on 10/31/18, at 7:38 a.m. d gripper socks on. Nursing moved the gripper socks; the le where the top of the gripper indented. NA-E then put to on 10/29/18, at 2:48 p.m. I)-A stated R78 had more legs than he has had before. if R78 received a diuretic r, stated he used the "tubi he swelling. FM-A stated R78 ince last care conference of at a.m. registered nurse (RN)-A	F	\$84	DEFICIENCY)		
	documentation of e RN-A indicated the	ord and verified there was not dema and/or not consistent. overall documentation of essment of edema was					

If continuation sheet Page 25 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/	02/2018
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	lacking. RN-A state monitored and docu location, extent, and were effective. During an interview 9:34 a.m. R78 sat in with tubular bandag removed the banda trace edema was n R78's right leg had mid-calf. During an interview director of nursing (edema should be d should include loca DON then stated we assessments shoul R7 had been intervi at this time R7 was swelling of both low compression wraps the edema, R7 said medication for the s remember. When a monitoring his eder When asked if the s down or to put if fee he could tilt his feet wheelchair. He ther R7 was observed o 12:45 p.m. and legs On 10/31/18, when a.m., 10:50 a.m. an noted to have his feet	d edema should routinely be umentation should include d determination if interventions //observation on 11/1/18, at n his wheelchair in his room ges to both legs. RN-A ages, stated the left leg had ot pitting. RN-A then stated 3+ edema from foot to r on 11/1/18, at 11:20 a.m. (DON) stated, monitoring of one daily; documentation tion and extent of edema. eekly more comprehensive	Fθ	\$84			

If continuation sheet Page 26 of 102

		AND HUMAN SERVICES			FORM	D: 12/28/2018 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245240	B. WING		11	/02/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
LAKE WINONA MANOR				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pa any regular monitor	-	F 68	34			
	RN-F confirmed that edema monitoring/a unable to state how had, but did know h "Ready Wraps" (to according to R7's c the nursing assistant when a nurse would said that "he has be only assess if he has because "this is his assessment is done nurses would rely o on a change in com During an interview director of nursing (erview on 11/01/18, 9:37 a.m. at R7 did not have regular assessments. RN-F was y much edema R7 currently he came to the facility with control swelling) which, are plan, are to be applied by nts daily. When asked about d assess R7's edema, RN-F een pretty stable" so would ad a change in condition a home." RN-F said a general e on all resident quarterly, but on nursing assistants to report dition.					
	chronicity and acute and that "quarterly i asked about R7, giv cardiac and respira history of hospitaliz stated R7 should ha regular basis and n R7's current physic	eness of a resident's condition is not frequent enough." When ven an extensive history of tory issues including a past ation for fluid overload, DON ave edema monitoring on a o less than weekly. ian orders included an order unide), a diuretic medication to					
	R7's care plan state volume deficit relate includes nursing as dressing, including Wraps." however, t	es that R7 is at risk for fluid ed to his ordered diuretic. Also esistants to assist R7 with application of the "Ready he care plan lacked nents and at what frequency					

If continuation sheet Page 27 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245240	B. WING			11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR					65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	and to watch/report overload. R73's change of co (MDS) an assessm R73 had diagnoses fracture and hyperte identified R73 had s moderately impaire daily living and was medications. R73's physician ord Furosemide (diureti (mg) daily in the mo- failure. R73's nutritional ca indicated R73 on 9- gain in 30/180 days Decreased intake, I 9-30-18. 10-26-18 s with decrease in ed at meals if not eatin R73's fluid volume 10/1/18, included P related to daily use within normal limits dehydration. Approa (signs and sympton fluids between mea practitioner/medica concerns. Nurse Aid weight, encourage nurse with any sign (constipation, fever increased pulse etco	t any signs symptoms of fluid ondition Minimum Data Set pent dated 10/4/18, identified s including Dementia, other ension. The MDS also short term memory problems, ed decision making skills for s administered diuretic ders dated 10/12/18, included: ic medication) 80 milligrams orning for congestive heart are plan dated 10/26/18, -28-18 had significant weight s caused by edema. 10/2/18, Fall with elbow fracture significant planned weight loss dema. Approach: Offer ensure	F 6	584			

If continuation sheet Page 28 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			` '			(X3) DATE SURVEY COMPLETED		
		245240	B. WING			11/(02/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
LAKE WINONA MANOR					65 MANKATO AVENUE VINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 28	Fe	684				
	and interview with r time. RN-A stated R73 had 3 pl mid calves. RN-A s all the way to her kr all the way to her m edema. RN-A state improved. RN-A state improved. RN-A state well, some was wei loss. RN-A stated th charting for the ede congestive heart fa elevate her legs. R feet on the tray tabl R73's physician pro- included, Assessme (congestive heart fa especially given sate extremity edema. H considerably. I doul intake. The pressur would anticipate thi although we do not echocardiograms. I overall beneficial to time. While she door failure exacerbation furosemide whethe dysfunction. Given be a poor candidate does have known v therefore, there is a has cardiovascular on furosemide 20 m	ogress note dated 8/31/18 ent and Plan: 1. CHF ailure) Probable diagnoses cral edema in addition to lower ler weight is up pretty bt it is from increased oral re is also up significantly. I s is diastolic dysfunction have any previous do not think it would be o obtain a cardiogram at this es have congestive heart h, treatment would be r or not it is systolic or diastolic her advanced age she would e for ischemic workup. She rascular calcifications and so a high likelihood that she also calcifications. We will start her ng daily. May need to be daily. She will likely need this						

If continuation sheet Page 29 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER	-	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 29	F	684			
	10/30/18 included, approximately 26 pr furosemide at the e potassium supplem per liter) daily. Her l about 2+ from feet i clear and no SOB (complaints. Blood p good control. She h furosemide daily sin dosing. Patient is re stocking or elevatin a bit more complain visiting. R73's progress note September and Oct September one pro included a compref edema that include degree of pitting. In were found that include degree and stated t in the notes to help the edema getting v example whether o pitting edema. RN-0 other factors such a of shortness of brea in the puzzle. RN-0	e practitioner visit note dated CHF the patient has lost ounds since the initiation of and of August. She is also on tent 10 mEq (milliequivalents lower extremity edema is to below the knees. Lings shortness of breath) pressures have been under tas been on 80 mg of the 10/12/18. Continue this esistant to compression ig her feet. She does become th when her daughter is es were reviewed for tober 2018. For the month of gress noted was found that thensive assessment of R73's d a description of edema and October two progress notes luded a comprehensive t's edema that included a dema and degree of pitting. 6 p.m. registered nurse what should be charted for RN-C stated should chart the the degree of pitting should be determine whether or not it's worse. RN-C stated for r not it is one plus or two plus C stated would also look at as weights or other symptoms ath, all pieces that fit together C stated need to assess all the na and really need to use your					

Facility ID: 00701

If continuation sheet Page 30 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING _			11/(02/2018
NAME OF F	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR					65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
PRÉFIX	REGULATORY OR LA Continued From para assessment skills v On 10/31/18, at 4:0 (RN)-A stated we have for edema daily. RN should include if the non-pitting and how wherever you would stated she expected indicate in the prog pitting and a descrip At 4:15 p.m. RN-A October for R73 an documented in Octo of pitting and descrip notes and verified t did not include a co A policy and proced requested and not p DRESSING CHANG R1's Diagnosis List diagnosis of localized lower extremity ede R1's current physic an order dated 10/3 extremity (LLE): 1.1 wound cleanser 2.1 Apply no-sting barri	SC IDENTIFYING INFORMATION) age 30 when assessing the patient. 17 p.m. registered nurse ave pathway charting on R73 N-A stated documentation e edema was pitting or v far the edema extends d have the edema. RN-A d the nurse assessing to ress notes the degree of ption of the degree of edema. pulled up progress notes from id verified the two notes ober the included the degree iption of the edema were her he other notes documented omplete description of edema. dure on edema monitoring was provided. GE: c, dated 11/1/18, included ed edema (dependent bilateral	PREFIX		CROSS-REFERENCED TO THE APPROPR		COMPLETION
	and ABD (abdomina and tape, tubigrip a Treatment: to right Cleanse with norma Pat dry with gauze barrier to intact and weeping areas with	al pad) 5. Secure with kling and ace 6. Change once daily. lower extremity (RLE): 1. al saline or wound cleanser 2. (gentle) 3. Apply no-sting a macerated skin 4. Cover maxorb (calcium alginate) with kling and tape, ace					

Facility ID: 00701

If continuation sheet Page 31 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED	
			· <i>·</i>			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245240	B. WING			11/(02/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	wraps 6. Change tw under control change During observation registered nurse (R change treatment to removed the old dre and cleansed both Dermal Wound Cle RN-D placed a 4 x 4 skin of the shin area placed an 8 x 10 ab the Vaseline gauze. Vaseline gauze to k to R1's legs. RN-D and placed a 4 x 4 abdominal pads on with Kerlix (cling wr place with tape. RN (compression) over have ace wraps app During interview on director of nursing s to follow R1's physi the lower legs. FOLLOW UP PHYS R34's Diagnosis Lis diagnoses of chest obstructive pulmona R34's resident prog identified resident of it as 8 out of 10. Re medication. She ele (emergency room) cardiac issues. Res	vice daily, once drainage is ge once daily. on 10/31/18, at 10:31 a.m., N)-D provide a dressing o R1's lower legs. RN-D essings from R1's lower legs lower legs with SAF-Clens AF ranser and 4 x 4 gauze pad. 4 Vaseline gauze pad on the a of the right and left leg and bdominal pad over the top of . RN-D stated she applied the keep the dressing from sticking lifted up the abdominal pads gauze pad underneath the each leg, wrapped both legs rap) and secured the Kerlix in I-D applied a tubigrip reach lower leg. R1 refused to plied to each lower leg. 11/01/18, at 10:04 a.m., the stated she would expect staff ician orders for treatment of SICIAN VISIT: st, dated 11/1/18, included pain unspecified and chronic	F	584				

If continuation sheet Page 32 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/(02/2018
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	has a history of. Re past and that could want to get it check she was feeling hot complained of neck Resident denied ha voiced concerns tha a heart attack. I too (9:45 p.m.) and got (0xygen) saturation pulse 85, respiration (10:00 p.m.). Reside to the ER. R34's emergency d 10/13/18, included I with physician within R34's record lacked primary physician within R34's record lacked follow up within one recommended per to During interview on stated R34 had not after the ED visit an documentation R34 informed R34 was s During interview on DON stated if an or physician in 1 to 2 w order sheet upon re department (ED), th stated staff can lool	laints of neck pain, which she esident had three strokes in the lead to a heart attack. I just the out. Resident told me that tout not clammy. She c pain and shortness of breath. Aving any chest pain. Resident at she thought she was having k residents vitals at 21:45 temperature of 98.1, O2 90% on one liter, BP 212/81, ns 22. BP 197/74 at 22:00 ent decided he wanted to go lepartment (ED) note dated Impression and Plan: follow up n one to two weeks. d documentation R34's vas informed R34 was seen in documentation of a physician e to two weeks as the ED note. 11/01/18, at 10:19 a.m., RN-F been seen by the physician nd R34's record had no 4's primary physician was seen in the ED on 10/13/18. 11/01/18, at 10:27 a.m., the der to be seen by the weeks was not written on the eturn form the emergency nen there was no order. DON k at the ED progress note, but p with primary physician in one	F 684			

If continuation sheet Page 33 of 102
		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT AND PLAN C	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				5 MANKATO AVENUE INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686 SS=G		Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 6	86			12/11/18
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa assess new pressu provide services an assessed/ordered t new pressure ulcers residents (R46) who to the sacram and of facility. Also had a s As a result of not as and not providing re and as assessed R Findings include: The facility's policy included the definiti Stage 1- Non-blanc Intact skin with loca erythema (redness)	sure ulcers. rehensive assessment of a must ensure that- es care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and ressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced ion, interview and document ailed to comprehensively re ulcer on sacrum and d treatments as o promote healing and prevent s from developing for 1 of 2 o had a stage 4 pressure ulcer developed a stage II ulcer in stage IV pressure ulcer on hip. ssessing new pressure ulcer epostioning services timely			F686 R46 S Care Plan was reviewed and updated to include specific offloading cares on 11/30/2018. Updated stand work for Chair Positioning as well as Skin Care policy to define offloading techniques was updated on 11/30/20 All residents screened for necessity update care plan with offloading techniques. All nursing staff will be trained on offloading standard work 12/11/2018. 8 Random weekly audit be performed by the Nurse Manager Designee x 8 weeks. Results will be brought to the QA/QI Committee for further recommendations.	g dard s the and D18. to to by ts will r or e	

If continuation sheet Page 34 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	Stage 2-Partial-Thick dermis. Partial-thick exposed dermis, pr ulcer. The wound b and may also prese open/ruptured bliste and deeper tissues tissue, slough and e stage should not be associated skin dar associated dermatii (inflammation of ski related skin injury, o tears, burns abrasio Stage 3-Full-thickne skin loss of skin in v be visible in the ulce epibole (rolled woun Slough and/or esch obscure the depth o tissue damage varie areas of significant wounds. Undermini Facia, muscle, tend bone are not expos obscures the wound pressure ulcer. Stage 4-Full-thickne exposed or directly tendon, ligament, ca Slough and/or esch parts of the wound and/or tunneling oft anatomical location	ecede visual changes. ckness skin loss with exposed kness loss of skin with esenting as a shallow open ed is viable, pink or red, moist ent as an intact or er. Adipose (fat) is not visible are not visible. Granulation eschar are not present. The e used to describe moisture mage including incontinence tis, intertriginous dermatitis in folds), medical adhesive or traumatic wounds (skin	F	586			

If continuation sheet Page 35 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa ulcer.	ge 35	F 6	86			
	dated 11/1/18, inclu	st located on admission form ded dementia without nce, and pressure ulcer of					
		te dated 8/8/18, indicated R46 in June 2018, and was 99					
	assessment dated a cognitive skills for of severely impaired, a rejected care during assessment period was not ambulatory assistance of one s transfers, dressing, required extensive toileting. The MDS frequently incontine incontinent of bowe indicated R46 was a stage 4 pressure pressure ulcer. The pressure reducing of nutrition intervention application of nonsu	The MDS also indicated R46 y, required extensive taff member for bed mobility, and personal hygiene, and assistance of two staff for further indicated R46 was ont of urine and occasionally I. In addition, the MDS at risk for pressure ulcers, had ulcer and an unstageable e interventions included: device for chair and bed, ns, pressure ulcer care, and urgical dressings.					
	-Ultram (pain medic day (start date 10/3 -Regular diet with E with all meals (start -Left hip treatment daily, right hip pad	nsure (dietary supplement)					

If continuation sheet Page 36 of 102

PRINTED: 12/28/2018

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	over eschar and co Kerracel. Secure wi tape if needed. Obs same dressing, tho every three days. If registered nurse (R date 9/29/18) -Sacral wound: 1)cl cleanser, pat dry. 2 Solution damp to dr 3)cover with 4 x 4 A change three times R46's undated pres Assessment (CAA) admitted with an un ulcer that was infect was at risk for press incontinence, poor assistance to move over any one site, a mattress or seat cu "Care Plan" include R46's care plan date was resistive to car to leave resident ald and re-approach; if another staff appro- care plan dated 10/ stage 4 sacral decu to left hip, did not id that was identified c indicated R46 had i impaired cognition,	keep area dry, apply maxorb ver with Mepilex AG form or ith paper tape or Medipore serve daily, you may use the ugh and change dressing area opens please notify N/wound care nurse. (start eanse wound with wound) apply ¼ normal Dakins ry using kerlix, pack lightly. ABD. 4) secure with tape. 5) a day (start date 9/7/18). sure ulcer Care Area indicated R46 was newly astageable sacrum pressure eted. The CAA indicated R46 sure ulcers related to nutrition, required staff e sufficiently to relieve pressure and required pressure reducing shion. Under the heading ed, "Revise current plan". ted 10/11/18, indicated R46 res at times and directed staff one for short period of time continued to be resistive have ach. R46's skin impairment 11/18, indicated R46 had a ubitus ulcer and black eschar fentify the lower sacral wound on 9/11/18, and further impaired skin integrity related impaired mobility, vas resistive to cares.	F	586			

If continuation sheet Page 37 of 102

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391			
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT	E SURVEY IPLETED			
		245240	B. WING			11/	02/2018			
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE W	INONA MANOR		865 MANKATO AVENUE WINONA, MN 55987							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 686	-Staff to assist reside one hour and as nee to avoid having her from side to side if a -Nursing to monitor concerns, consult w -Nursing to update practitioner) as nee to skin status. -encourage fluids, o -nursing staff to foll updating wound can as needed with con -Offer snacks betwo Prostat -assist resident with hours and as needed and dry; staff to upd wound noted to be -observe skin for re symptoms of break evaluate, update nu pain to evaluate as -pressure reducing -2 staff with lift shee as needed -assure foam paddi R46's Nursing Assis 10/11/18, included: staff assist for repo continued risk for fu R46's Skin Alteratio following document -9/5/18, note includ centimeters (cm) x tunnel 4 cm. Contin	dent with repositioning every eeded and when in bed attempt lay on her back repositioning she will tolerate. r and chart weekly on all skin with wound nurse as needed. MD/NP (medical doctor/nurse eded with changes or concerns offer lotion to skin low wound care orders re nurse from clinic or MD/NP neerns een meals, Ensure and h bathroom needs every two ed with goal to keep skin clean date nurse if dressing to sacral soiled to change as needed edness, bruising, or signs and adown and update nurse to urse with any verbalizations up needed pad to wheelchair when up et, to move resident up in bed ing intact to left hip. stant Care Plan dated REPOSITIONING: I need 1-2 ositioning every hour due to my urther skin breakdown.	F 6	86						

If continuation sheet Page 38 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	INONA MANOR			86	55 MANKATO AVENUE		
				W	/INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 38	F 68	86			
		age was thick and straw					
		oted. Continue to provide					
	repositioning.	ded: Sacral wound dressing					
	change completed						
	assessment a smal	Il red open area about an inch					
		d was noted. Assessment did					
		ements of the sacral wound					
	nor the new open a	irea. ded: Wound on sacrum					
		d from yesterday, drainage					
		lor. New open area size of					
		ow the initial ulcer is noted					
		ing. Resident verbalizes a lot					
		h care to wounds and I. The note did not reflect a					
		sessment of the sacral wound					
		d below the stage IV wound.					
		ded: The original sacral					
		cm, with tunneling and					
		a second opening that is 0.5 uring 3.5 cm from one wound					
	to the other. There						
		neasuring 4 cm in some areas.					
		ssure relieving cushion and					
		ositioned by staff. Continue					
		his point there is not another					
	0	e better for infection control.					
		ded: Ulcer on buttocks ength x 1.5 cm width x 2.5 cm					
		age with no odor. Tiny hole					
		ulcer tunnels through 0.7-0.8					
	cm x 0.3-4 cm.	-					
		ded: Stage 4 sacral ulcer 2.3					
		n. Circumferential undermining					
		, wound communication to ong gluteal cleft: second					
		0.2 cm x 0.1 cm and the					
		superior open area and					

Facility ID: 00701

If continuation sheet Page 39 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245240	B. WING	i		11/(02/2018			
NAME OF	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE W	INONA MANOR		865 MANKATO AVENUE WINONA, MN 55987							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 686	communicate is 3.5 indicated the wound deteriorate dependi and other factors. A up in her chair. Wor heal when sitting up on bed rest with sid does have two area caused by both pre- so side to side repo- unless she has a di patient is up in chai activities, will keep any concerns. -9/26/18, Sacral ulc 2.8 cm, tunneling at at 12 o'clock, unabl -10/4/18, note indic was done; moderate drainage. Just below noted. -10/8/18, note indic measured 1.5 cm x 6 and 12 o'clock po below the larger sac 0.5 cm in diameter. -10/10/18, note indi openings: lowest or and upper opening tunnels from 6 o'clo 11 o'clock is underr -10/17/18, note indi cm length, less thar and 12 o'clock but f 1.5 cm. Smaller one cm with 2 cm depth -10/23/18, note incl cm with 1.75 cm de	is cm. The note further d is chronic and may ing on patients nutrient intake at this time she prefers to sit unds like this do not typically o on it and patients usually are le to side positioning. Patient as on her hips that are problem ssure and hardware migration, ositioning would be difficult fferent support surface. Since r and likes to participate in treatment unless staff report er stage IV, 2.8 cm x 1.8 cm x t 6 o'clock 3.3 cm and 2.0 cm e to visualize tunneling. ated sacral wound treatment e amount of bloody yellow w wound bed a pen tip hole ated stage 4 sacral wound 2.5 cm x 2.8 cm, tunneling at sitions. Second open area cral ulcer measuring less than (did not include a depth). cated sacral region had two ne measured 1.4 cm x 1 cm is 2 cm by 1.2 cm wound bck 4.2 cm. From 6 o'clock to nined about 1.2 cm. cated sacral ulcer less than 2 n 1 cm width, depth 6 o'clock illing in with tissue less than e below tunneling 1 cm x 0.5	F	686						

If continuation sheet Page 40 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa 2.5 cm depth. Appli R46's record lacks refusals to reposition R46's last physician primary physician h empirically with antii infection and new o wound. The note im- sacral ulcer had im- note referenced are included the left hip measured 2.8 cm b cm. The physician y development of the less than 0.5 cm in visit. During an observati R46 was transferred commode. R46's sa intact. R46 cried ou Licensed practical r pain medication alro completed the dress LPN-C indicated R4 with tunneling to a y morning cares were medication assistar assistant (NA)-H, R wheelchair via full b -At 7:53 a.m., R46 y	Age 40 ied dressings as ordered. evidence of documentation of on/offload. In visit dated 10/8/18, indicated had treated R46's wound ibiotics related to question of on-set of tunneling in the dicated since that time the proved and was stable. The eas of impaired skin which o and Stage 4 sacral ulcer that by 1.8 cm with a depth of 2.8 visit note did not reflect the e new wound that measured diameter the same day as tion on 10/31/18, at 7:15 a.m. d from bed to bedside acral dressing was dry and ut "ohhhh" during the transfer. nurse (LPN)-C stated she had eady that morning and had using change to sacral wound. 46 had a pea sized open area wound right below. After e provided by trained int (TMA)-A and nursing 846 was transferred to her body lift at 7:40 a.m. was wheeled out of her room		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	until 8:41 a.m.	vas wheeled to an adjacent				

If continuation sheet Page 41 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	-At 8:48 a.m. TMA-, from the dining room her room, offered to to a straight sitting p not have to use the bottom was shifted because she had be NA- confirmed the no offloading (the remo- points to prevent tiss the sacral region. -At 9:15 a.m. R46 w offered toileting by transferred R46 via commode; the sacral be soiled by watery -At 9:37 a.m. LPN-0 transferred R46 into hands, donned glow dressing which rever were both soiled wir removed gloves, sa gloves, cleansed we hygiene to apply or the lower wound is the bottom of the w wound was not pac upper wound packin bottom of the lower -At 10:15 a.m. R46 room sitting up in he -At 10:50 a.m. R46 sitting in wheelchain -At 12:01 p.m. TMA pulled R46 aside ar	A and NA-E removed R46 m and wheeled her back to bileting, and repositioned her position. NA-E stated, R46 did restroom, and verified R46's from the left to the right een leaning more to the left. repositioning was not oving of pressure to pressure usue damage) of pressure to was wheeled into her room and TMA-A. TMA-A and NA-I full body mechanical lift to the al dressing was observed to loose stool. C entered the room. NA's o her bed. LPN-C washed res and removed soiled ealed 2 sacral wounds that th watery loose stool. LPN-C unitized hands, donned new ound, and repeated hand dered treatment. LPN-C stated newer and are conjoined at ound. LPN-C stated the lower ked with anything and the ng could be visualized at the wound. was observed in the activity er chair. was wheeled to another ated down the hallway. continued to be in the activity	F 6	86			

Facility ID: 00701

If continuation sheet Page 42 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			-	865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	pressure for any ler area. During an interview TMA-D indicated re making sure the res in their chair; makin and/or back far end offloading was used area. TMA-D stated should be done for During an interview nursing assistant (N repositioning and of NA-K then stated if ulcer on their bottor them off the area of NA-K indicated una offloading should of During an interview LPN-C stated resid repositioned/offload tissue re-perfusion. resident should be indicated R46 was repositioned/offload indicated R46 did n a standing lift which that would be worse During an interview registered nurse (R assessment notes a assessments were wound had not bee RN-A stated the set	ngth of time to the buttock on 10/31/18, at 4:22 p.m. epositioning had to do with sident was positioned correctly ng sure they were not leaning ough. TMA-D then stated d to keep pressure off of the d offloading to reduce pressure about five minutes. on 10/31/18, at 4:26 p.m. NA)-K used the terms ffloading interchangeably. someone had a pressure m then you would have to get f pressure to relieve pressure. wareness of how long ccur for tissue re-perfusion. on 10/31/18, at 4:33 p.m. ents should be ded for at least 2 minutes for LPN-C indicated ideally the laid down in bed. LPN-C supposed to be ded every hour. LPN-C ot like to lay in bed, and used n was harder on her arms, and	F	586			

If continuation sheet Page 43 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			-	65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	RN-A stated she wa wound was a part of the physician is sup changes in skin cor wounds. RN-A indic physician had been the second wound sacrum). RN-A indic repositioned/offload least 1-2 minutes for indicated staff shou offered R46 reposit of her bottom while adequately relieve p because of the loca R46 refused, staff sher, reported to the refusals. During an interview director of nursing (should be compreh and at a minimum of the NA's moved the while in the wheel of The DON said that better job with repo pressure off the wo should be reposition pressure for 1-2 mi re-perfusion. Facility Skin Care p indicated purpose t prevent pressure uf healing of pressure present and to prev additional pressure	as not aware if the second of the first wound. RN-A stated oposed to be alerted with ndition or changes to existing cated there was no record the notified of the development of (located below the stage IV on cated residents should be ded off of pressure areas for at or tissue re-perfusion. RN-A uld have attempted and/or tioning/offloading; and shifting in the chair would not pressure to the sacral area ation. RN-A further stated if should have re-approached e nurse, and document of weekly. DON was informed e resident from side to side chair and called it off loading. the NA's could have done a usitioning/offloading to shift ound. DON stated residents ned/offloaded off the area of nutes in order for tissue	F	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURV COMPLETEN B. WING NAME OF PROVIDER OR SUPPLIER 245240 B. WING 11/02/201			AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
	STATEMENT	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		PLE CONSTRUCTION	(X3) DATI	E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			245240	B. WING			11/0	02/2018
	NAME OF I	F PROVIDER OR SUPPLIER	•	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR 865 MANKATO AVENUE WINONA, MN 55987	LAKE W	WINONA MANOR						
PRÉFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
F 686 Continued From page 44 F 686 Physical exam and the skin assessment tools to determine an individualized skin care plan for each resident. This may include interventions: A) protect skin against the effects of pressure, friction, shearing, moisture, or bruising interventions B) encourage optimal nutrition and hydration. Update dietary staff to review for appropriate protein supplement C) educate staff, residents, and families on risk factors and prevention plan when potential areas are identified E)update care plan, MAR/TAR with specific interventions and treatment. IV. When a skin ulcer or ther wound is identified, an assessment of that specific wound will be completed and documented in the electronic medical record by the nurse. The assessments of the area should be added to the MAR/TAR. B) Treatment of the wound or pressure ulcer, other wound is possible risk factors to be identified. C) A review of the resident's care plan and medical status-any other possible risk factors to be identified. Wound care nurse as needed to consult F. If the wound has not improved, contact the MD/NP/Wound specialist for change in treatment. V. Any resident education will be documented. VI. Nursing staff who will be providing care for receive ulcer education annually. They will also be instructed on interventions specific for each resident.	F 686	physical exam and determine an indivi each resident. This protect skin against friction, shearing, m interventions B) end hydration. Update of appropriate protein residents, and fami preventative measu preventative measu prevention plan who identified E)update specific intervention IV. When a skin uld an assessment of t completed and doc medical record by t include: A) measure or bruising, noting of condition of surrour signs of infection. V the area should be Treatment of the we implemented. C) A plan and medical st factors to be identifi ulcer. E. Update the to consult. F. If the contact the MD/NP, in treatment. V. any resident edu VI. Nursing staff wh receive ulcer educat be instructed on int resident. Facility protocol Sta	the skin assessment tools to dualized skin care plan for may include interventions: A) the effects of pressure, noisture, or bruising courage optimal nutrition and dietary staff to review for supplement C) educate staff, lies on risk factors and ures D) Institute an immediate en potential areas are care plan, MAR/TAR with and treatment. eer or other wound is identified, hat specific wound will be umented in the electronic he nurse. The assessment will e pressure ulcer, other wound condition of wound bed, nding tissue, and any other Veekly skin assessments of added to the MAR/TAR. B) ound or pressure ulcer being review of the resident's care tatus-any other possible risk ied. D) Identify type of skin e wound care nurse as needed wound has not improved, /Wound specialist for change andard Work Chair	F	586	5		

If continuation sheet Page 45 of 102

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		O. 0938-039 ATE SURVEY DMPLETED		
				<u> </u>			
	PROVIDER OR SUPPLIER	245240	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1/02/2018		
	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987	<u>, </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 686	residents unable to steps included: 1) r repositioned every do so themselves. repositioned in chai side or the other to	reposition themselves. Major esidents should be two hours if they are unable to	F 68	6			
SS=D	CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en §483.25(d)(1) The i as free of accident §483.25(d)(2)Each	its.	F 68	9	12/11/18		
	by: Based on observat review, the facility fa assess for root cau implement interven injury for 2 of 3 resi for accidents. Findings include: R73's change of co (MDS) an assessm R73 had diagnoses fracture and hyperta identified R73 had s moderately impaire daily living and requ	NT is not met as evidenced tion, interview and document ailed to comprehensively se analysis related to falls and tions to minimize the risk for dents (R73 & R78) reviewed andition Minimum Data Set ent dated 10/4/18, identified including Dementia, other ension. The MDS also short term memory problems, d decision making skills for uired extensive assistance for fers, dressing, toilet use and		F689 R73 S Care Plan was reviewed and updated by 11/28/2018. R78 No longer resides at the facility. The Quality Assurance Reports/Grievances policy w updated to include required root cause analysis. All licensed nursing staff will b educated by 12/11/18. Random Audits o post fall assessments will occur weekly to 5 by a nurse manager or designee. Results will be brought to the QA/QI Committee for further recommendations			

If continuation sheet Page 46 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa personal hygiene.	ge 46	F 689)		
	R73's care plan inc traumas Related to fx (fracture) of left e Goal: Will have no fall. Approaches: As transfers, toileting. hours. Bed in lower to ask for assistance position of recliner call staff for any ass call light to be hook on tray table d/t (du resident increased and throw on the flor resident's personal checks during night chair no bed, (No a R73 was observed sitting in her recliner television; call light R73 was observed sitting in her recliner table in front of her, on the paper. The ts soft call light was ma recliner and she was R73 was observed sitting in her recliner table, with a spoon watching television, her recliner, bell on R72 was observed	luded, Problem: fall risk : impaired mobility, pain recent abow, cognitive impairment. major injury as a result of a ssist with ambulating Check comfort level every two , locked position. Encourage e.e. Keep control to alter out of view. Offer reminders to sist needed. (per family ok) ed to bed at all times and bell e to) call light on chair causing agitation and she will unhook or. Assure non-skid pad in chair, and increased 1-hour t when sleeping in personal larms per daughters request). on 10/29/18, 4:12 p.m. to be er in her room watching was attached to her recliner. on 10/31/18, at 6:57 a.m. er in her room, with the tray , using a pen and is scribbling bell was on the tray table; the ext to her attached to the as wearing gripper socks. on 10/31/18, at 8:04 a.m. er, feet propped on base of tray in her coffee mug stirring it, , call light in reach attached to tray table. on 10/31/18, at 9:54 a.m. in at was elevated at this time;				

If continuation sheet Page 47 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	call light attached to and was sleeping. R72 was observed her room asleep in positioning, bell on positioned on the fle call light was clippe R73's incident reporesident was found straight out in front against the side of the fresh blood noted of scalp. Quarter size laceration noted, ble spontaneously. BP (pulse) 68 Resident staff and gait belt a assessment reveals reluctance to use le appears to be in the (blood pressure) 87 unequal but reactive sluggish. Unable to hearing deficit. Was result in injury: Yes. scalp, left shoulder harm: moderate ha you fell: unable to re and gripper socks. fall: unsteady gait, i Mental status at time unable to follow dire unknown. Call butto on at time of fall: No personal alarm. Ha last 30 days: Yes 8-	at 11/01/18, at 7:46 a.m. in the recliner, pillows placed for tray table, feet were oor, dressed for the day, and d to her recliner. rt dated 9/30/28, included, seated beside the bed, legs of her back and head leaning the bed. Moderate amount of n the floor, bleeding and hematoma with a small eeding had stooped (blood pressure) 117/64, P t assisted to feet with three	F	\$89			

If continuation sheet Page 48 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245240	B. WING			11/	02/2018
NAME OF I	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				8	65 MANKATO AVENUE		
LAKE W	INONA MANOR			V	VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 48	Fe	689			
	p.m. Date of incider 7:45 a.m. Day of we injury? Yes, lacerati arm pain which was care as a fx (fractur resident was placed returned with sling f Factors: On assess female resident with congestive heart fa osteoarthritis, mild lung nodules, and h vision is very poor i only see shadows a to her as her hearin ability to always red limitations is signified does not ask for as call light in which sh un-hooking call ligh room in which she has been more coo (history) of getting u always using her wa noted to come out i as support but is all redirection and staf seen her walking in recent complaints of had recent increase significant lower ex extended to upper f increased complain Medication status: I in the past week: La Was care plan upd	stigation dated 9/30/18 at 8:51 ht: 9/30/18. Time of incident: eek Sunday. Did fall result in ion to back of head and left is later dx (diagnosed) in urgent re) of the left elbow and d in long-term hard splint and to help bearing of weight. Risk sment, this is a 90 year old h noted dx (diagnosis) ilure, venous stasis dermatitis, cognitive impairment, noted fix (history) of anemia. Her n which she reports she can and you have to be very close ag is significantly impaired. Her cognize her needs and cantly impaired and often she sistance and does not like her he has hx (history) of t and throwing it across the was given a bell to use and operative at times. She has hx up independently and not alker has in the past been n hall using her bedside table most always cooperative with f assistance when they have dependently. She has had no of being dizzy although has e in Lasix secondary to tremity edema, which thigh region and was offering its of lower back and leg pain. Lasix, ultram. New medication asix increased on 9/23/18. ated at time of the fall: Yes- rsonal alarm has been					

If continuation sheet Page 49 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	significant impaired left arm. Resident f fall: 6. Score followi risk for falls: yes. R73's ED(emergen provider note dated complaint: Residen 0800 this morning. of her head and son Present Illness-Pro female presents too falling at Lake Wind	s time d/t (due to) her I mobility with inability to use all risk score: Score prior to ing fall: 10. Resident is at high cy department)/urgent care I 9/30/18, included chief t is here after falling around Patient has laceration to back re left elbow. History of vider: R73 is 90-year-old day with her daughter after ona Manor. Patient does not	Fθ	89			
	Patient reports a gr reported by the nur- that is nauseous co- that this occurred a the back of the hea pain in the elbow. P in the left elbow. Sh here. She denies an	bes have a history of dementia. The eat deal of left arm pain. It is se from Lake Winona Manor onsciousness. It is reported t 8 AM. She has laceration to d on the left side as well as Patient is reporting mostly pain the does not recall why she is my other systemic systems or as incredibly hard of hearing.					
	(TMA)-A stated R73 her call light cord if stated she does had she can ring if she if an observation, R73 be clipped to her re care planned to not and was observed to the recliner attach to	1 p.m. trained medication aide 3 would always get agitated by it was hooked to her chair and ve a bell on her tray table that needs us. At 3:16 p.m. during 3's call light was observed to cliner. TMA-A stated it was a be attached to her recliner to remove the call light from he call light to her bed. 7 p.m. registered nurse					
	(RN)-A stated R73	had a history of getting up on It of bed and fractured her					

If continuation sheet Page 50 of 102

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM MB NO.	12/28/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			-	865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	elbow. RN-A stated happened she was stated the activity a RN-A stated R73 haverified the fall door complete investigat include a root cause include staff intervie not include if the cause RN-A stated self-tra- the fall, but we do not self-transfer. RN-A into place at the time alarm, but stated we daughters request. completing a root cause interventions would implemented to mir RN-A verified the cause interventions would implemented to mir RN-A verified the cause not clip the call light first came in, she we throw it off. RN-A st follow the care plan recliner. On 11/01/11 through observation recliner and stated R78's Diagnosis List diagnoses of histor failure, hypertension renal disease stage R78's annual Minim 10/11/18 indicated I decision making wa MDS also indicated assistance from two mobility, and require	when R73 was asked what unable to respond. RN-A t time of fall was unknown. ad cognitive impairment. RN-A umentation was not a tion of the incident, as it did not e analysis of the fall, did not ews regarding the fall and did are plan was being followed. ansferring was the reason for not know why she was trying to verified the intervention put he of the fall was a personal as no longer being used per RN-A verified without ause analysis of the fall the able to determine what be appropriate to be himize the risk of further falls. are plan for R73 included to t to the recliner as when she yould unclip the call light and tated she expected staff to n call light was clipped to the would reassess. at dated 11/1/18, included y of falls, congestive heart n, diabetes type II, and chronic	F	589			

If continuation sheet Page 51 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR			-	365 MANKATO AVENUE NINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	MDS further indicat since admission or R78's care plan dat Problem: fall risk go as a result of a fall. 10/14/18, included ambulating, transfe comfort levels ever position. Encourage Resident is to be w socks on at all time wheelchair and beo R78 was not attem checks to ensure th place and functionin wheelchair/recliner assisted to bed by 8 request otherwise t and not left in his ro During an observat R78 sat in his whee family member (FN underneath his righ just above his eyeb approximately 2-3 i personal safety alat During an observat R78 sat in his whee present. R78 had p wheelchair. At 9:33 walked into the root R78's progress not p.m. indicated R78 emergency department	ted had one fall without injury the last assessment period. ted 10/4/18, included; bal of will not have major injury The interventions dated the following: assist with erring, and toileting. Check y 2 hours. Bed in lower, locked e to ask for assistance. ear his shoes or have gripper es. Personal alarm on d. Check at 9:00 p.m. to ensure pting to self-transfer. Frequent hat personal alarm was in ng. Dycem no-skid pad in when up. R78 was to be 8:30-9:30 p.m. per family hey ask that he be out by staff bom on night shift. ion on 10/29/18, at 2:30 p.m. elchair in his room next to 1)-A. R78 had his eyes closed, it eye was a fading bruise and prow was a fading scar nches long. R78 had a rm on his wheelchair.	F	589			

If continuation sheet Page 52 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa eye.	ige 52	F 6	89			
	R78's incident report the date of fall was the writer of the rep when a loud bang w the hallway lying on on his side, about 1 report further indica activated, did not ha the time, and there floor. The report als contusion the size of laceration above his indicated the fall wa compress was appl was minor harm ev question, Why do y unable able to resp cognitive deficits. In resident assisted of and into his wheeld into bed at 10:00 p. R78's emergency d 10/13/18, at 10:57 p out of his chair and ground level. The n his head and result laceration around h indicated the lacera length with a superf sutures. R78 was th facility. R78's Post Fall Risl at 2:16 a.m. indicate was at high risk for	ort dated 10/14/18, indicated 10/13/18, at 10:32 p.m. and oort was down another hallway was heard. R78 was found in a the floor face down, slightly 10 feet from his door. The ated R78's personal alarm was ave an incontinent brief on at was a pool of blood on the so indicated R78 had of an egg with a deep s right eye. The report then as not witnessed, a cold lied, and the degree of harm rent. In response to the report you think the you fell: resident ond secondary to significant mmediate interventions: ff the floor with the full body lift thair. New interventions: assist .m. rounds. Repartment visit note dated p.m. indicated R78 had fallen described as a fall from note indicated R78 had struck ted in a hematoma and a large his right eye. The note further ation was 6 centimeters in ficial depth that required six hen discharged back to the k Assessment dated 10/14/18, red R78 had a history of falls, falls, has diagnosis of avioral disturbance, has					

If continuation sheet Page 53 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	incontinence. The a indicated the hallwa dimmed due to the R78's Post Fall Inve 3:20 p.m. identified incident report docu the fall R78 require above his right eye. indicated protective place during the fall charting indicated th staff were not able Risk Factors: On as year old male with r Alzheimer's with va behavioral disturbat poorly controlled dia cognificantly impaire anticipate all his ne light even with remi remained unchange staff assist and wal depends on his mo times to become ag physically aggressiv evening prior to the to be very agitated self-transfer followe his wheelchair in wi assisted to persona did then attempt to the fall. Resident's o unchanged he has respiratory status n this recent fall he has	assessment indicated R78 ay where R78 had fallen was	F	589			

Facility ID: 00701

If continuation sheet Page 54 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING _			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				5 MANKATO AVENUE INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	discomfort. Second agitation prior to fal been revised for res in chair and per fan assisted to bed by 8 ask that he be out be room. The investiga no recent changes the last 90 days, an both occurred durin no pattern to time of R78's fall incident rr indicated R78 had a injury at 6:25 p.m. i included: writer was alarm going off. We resident on his left what he was doing trying to go home, of The report indicated floor was slippery), appropriate parties. The incident report and/or ongoing fall R78's Post Fall Inve included the recom report and included and unsteady gait. stable overall with p impaired mobility. T there was not a new staff/resident/or fan reviewed by the reg the fall. The investig	lary to noted increased I during the shift care plan has sident to be assisted to be not hily request resident to be 3:30-9:00 p.m. otherwise they by staff and not left in his ation report further indicated, in status, had had two falls in id pattern of falls identified as ig his personal chair however, if the falls. eport dated 10/19/18, an unwitnessed fall without in the dining room. The report is coming off the elevator heard ent into the dining room to find side on the floor. When asked resident stated that he was can you please take me home. d R78 was wearing slippers, report did not indicate why the vital signs, and notifications to did not identify immediate	F 68	89			

If continuation sheet Page 55 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			-	865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	last three months a of the falls was indiv The Investigation re analysis and/or root 10/19/18, and furthe identification and/or of interventions rela During an interview family member (FM several falls and ha facility initiated the I three weeks ago that room visit and sutur indicated R78 had that an alarm on, and the into the hallway with family requested the supervision at night and didn't think staff proximity. During an interview nursing assistant (N for falls. NA-F indicated of his room and with when R78 became self-transfers they t provide distractions During an interview registered nurse (R occurred the nurse charting and comple RN-A then indicated do the fall follow-up talking with the tear	nd the relationship or pattern cated as "self-transfers". eport lacked a comprehensive t cause of R78's fall on er lacked evidence of evidence of implementation ated to that fall occurrence. on 10/29/18, at 2:30 p.m. I)-A stated R78 has had is had less falls since the low bed. FM-A stated R78 fell at resulted in an emergency res over his right eye. FM-A been sitting in his recliner with en he got up and walked out nout his walker. FM-A stated e staff provide him with more because he moved quickly, f were always in near	F	589			

If continuation sheet Page 56 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING	i		11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	RN-A stated, after t we discussed with t immediate interven his room and lay hit requested times. R report and the fall in confirmed based or not be determined agitation prior to the behavior analysis. If though R78 was for incontinent brief on assessment or diar RN-A then reviewed post fall investigation on 10/19/18, and in incident report and incomplete. RN-A in lacked identification and the post fall investigation thing it was talked a investigations were could not be comple During an interview director of nursing (and investigation re occurred on 10/13/ stated the expectat analysis of why the DON indicated the details of everything	the fall with injury on 10/20/18, family and determined the tion was to keep R78 out of m down in bed at the N-A reviewed the fall incident nestigation report and in the documentation it could what potentially caused R78's e fall because there was not a RN-A further indicated even und in the hallway without , a bowel and bladder y had not been completed. d the fall incident report and on from the fall that occurred idicated the both the fall the fall investigation were indicated the fall incident report n of immediate interventions vestigation lacked a sessment of the fall, risk ude a root cause, and lacked erventions. RN-A indicated the bous board to determine in, and when the team noticed about. RN-A further stated fall is constant and ongoing and	F	689			

If continuation sheet Page 57 of 102

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	GONNEOTION	IDENTIFICATION NOMBER.	A. BUILDII	NG	3	0011	
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	and details of the te did. Facility policy Cumu 1/2017, included the record is kept in ear medical record to fa patterns of causativ contributed to the fa indicated/directed th	eam discussion in what they ulative Fall record dated e purpose: A cumulative fall ich resident's electronic acilitate identification of ve factors that may have all. The policy	F 6	89			
	a licensed nurse ex records the blood p B) directed staff to r and chart in the ele C) chart fall in ECS checks if applicable assessment x 24 ho D) Provider will be r for significant injury Leaving a message if no significant injury E) Care plan will be necessary after eac F) Falls discussed v including therapy to	kamines the resident and pressure and pulse. notify family/significant other ectronic medical record. 5, reporting vital signs, neuro e and chart follow-up ours. notified of all falls immediately v or change in resident status. e/fax during clinic office hours ry. e reviewed and updated if					
F 692 SS=G	interventions. G) Follow-up recom at that time. H) Overall falls reco quarterly by Quality patters noted. Nutrition/Hydration CFR(s): 483.25(g)(§483.25(g) Assisted (Includes naso-gas	nmendations will be discussed orded will be reviewed Assurance team if specific Status Maintenance	F 69	92			12/11/18

Facility ID: 00701

If continuation sheet Page 58 of 102

PRINTED: 12/28/2018

CENTER STATEMENT	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	ON	FORM / / <u>IB NO.</u> (X3) DATE	12/28/2018 APPROVED 0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		-		COMP	PLETED
		245240	B. WING			11/0	2/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	percutaneous endo enteral fluids). Bas comprehensive ass ensure that a reside §483.25(g)(1) Main of nutritional status, desirable body weig balance, unless the demonstrates that to preferences indicat §483.25(g)(2) Is off maintain proper hyd §483.25(g)(3) Is off there is a nutritiona provider orders a th This REQUIREMEN by: Based on observat review, the facility fa comprehensive hyd and monitoring, prio of tube feeding, in of for 1 of 1 resident (1 hospitalization. The for R56 who becam sustained acute rer Findings include R56's Diagnosis Lis diagnosis of trauma chronic kidney dise cognitive impairmen added 9/17/18, inclu-	scopic jejunostomy, and ed on a resident's sessment, the facility must ent- tains acceptable parameters , such as usual body weight or ght range and electrolyte e resident's clinical condition this is not possible or resident e otherwise; fered sufficient fluid intake to dration and health; fered a therapeutic diet when I problem and the health care herapeutic diet. NT is not met as evidenced tion, interview and document ailed to complete tration/nutritional assessment or to and/after discontinuation proder to prevent dehydration R56) reviewed for facility's failures caused harm ning severely dehydrated and	Fθ	92	F692 R56 \Box s Care Plan and nutritional monitoring were updated 11/29/2018 Hydration Management and Nutritio Risk Protocol policies will be update 12/4/2018. All tube fed residents we audited for hydration risk. Licensed nursing staff and Nutritional Special will be updated on new policy by 12/11/2018. 1 Random audit of the nutritional assessments will occur w x 5 by a Care Coordinator or design Results will be brought to the QA/QI Committee for further recommendat	nal ed by ere ists veekly nee. I	

If continuation sheet Page 59 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pa diagnosis of urinary R56's quarterly Min assessment dated of severe cognitive im supervision with ear during the assessm complaints of difficu- weighed 184 pound physician prescribe feeding tube and als mechanically altere indicated R56 recei averaged 501 cubic fluid via the feeding R56's annual MDS cognitive skills for d severely impaired a for eating. The MDS had no difficulty with weight of 179 pound prescribed diet for w tube feeding, and re and therapeutic dief R56's nutritional can identified R56 had b related to dehydratia and had swallowing included: weight wil (lbs) and would con meet his needs. Th directives for staff to intake, not use strav Ensure at 10:00 a.m 2:00 p.m. (8 ounces	nge 59 y tract infection was added. imum Data Set (MDS) 6/21/18, indicated R56 had ipairment, and required ting. The MDS indicated nent period, R56 had ulty or pain with swallowing, ds, had no weight loss, had a ed diet for weight gain, had a so had orders for a ed diet. The MDS also ived 51% of total calories and c centimeters (cc) or more of g tube. dated 9/19/18, indicated R56's daily decision making were and R56 required supervision S also indicated the resident h chewing or swallowing, a ds, was not on a physician weight gain, did not receive eceived a mechanically altered t. re plan dated 9/21/18, been hospitalized on 9/7/18, ion and urinary tract infection, g difficulty. The care plan goals II remain above 170 pounds nsume adequate intake to the care plan further included o ensure adequate fluid ws, and to give strawberry n. and chocolate Ensure at s) for additional calories. The	n	592	DEFICIENCY)		
	Ensure at 10:00 a.n 2:00 p.m. (8 ounces	n. and chocolate Ensure at					

Facility ID: 00701

If continuation sheet Page 60 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING	;		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	R56's hospital discl indicated R56 was 9/13/18. The hospit long-standing histor who just recently has endoscopic gastros 8/24/18. He was ad dehydration, hyperr acute kidney injury. indicated during the diagnosed with urin started on a course R56's nutritional as indicated R56 had I therapy to progress time the diet was m assessment further had increased how breakfast on most of further tube feeding decreased on 6/18/ intake at meals. Th decrease in amoun The Osmolite 1.5 w hours per day to run centimeters)/hr (ho p.m., with continued times a day becaus inadequate. The as required 2590 cc's indicated fluid intak inadequate as well therefore R56 conti	harge summary dated 9/17/18, admitted to the hospital on al note included: R56 had ry of traumatic brain injury, ad his percutaneous stomy (PEG) tube removed on mitted with obvious natremia (high sodium) and The discharge summary also e hospital course R56 was ary tract infection and was of antibiotics. sessment dated 6/29/18, been working with speech to eating by mouth and that at rechanical soft textures. The indicated R56's oral intake ever, R56 continued to refuse days and may improve with g reduction. Tube feeding was 18, to promote increased e note indicated another t of tube feeding would begin. yould be decreased to three	F	692			

If continuation sheet Page 61 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	also indicated the C held for one week t well and to determi between 185-190 lk lbs. and because flw water flushes would fluid intake would b The assessment fur monitor his fluid inta was to wean R56 fr for fluids and medic R56's next nutrition 7/23/18, and indica upgraded to a regu meats, whereas he tube feeding. The a been doing well wit for lunch and dinne breakfast, because assessment also in when he get up in t weight was 197 lbs intake of fluids rem R56's August 2018 Record (MAR) inclu orders: Tube feedir flush daily at 4:00 p start date of 7/30/18 The MAR further in started on 6/29/18, 130 cc's an hour tir discontinued on 8/5	Desmolite 1.5 feeding would be o see if he continued to eat ne if he could maintain weight os.; current weight was 189 uid intake was inadequate d continue to be provided and e re-evaluated in one week. rther indicated staff would ake on a daily basis. The goal om the tube feeding and need cations via the tube. al assessment was dated ted R56 was recently lar diet with ground or cut up had previously also had a assessment indicated he had h food intakes from 50-100% r with some refusals for he liked to sleep in late. The dicated R56 received Ensure he morning and his current , however also indicated: "Oral ains inadequate." Medication Administration uded the following physician ng-120 ml (milliliters) manual 0.m. to keep tube patent with a 8, and end date of 8/24/18. dicated the previous order that which included Osmolite 1.5, nes three hours was	F 692			

If continuation sheet Page 62 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245240	B. WING _			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	Continued From pa	ige 62	F 69	92			
		dated on constipation since new orders were obtained.					
		d assessment to determine sufficient according to					
	dated 8/14/18, and decreased 8 lbs. in Mighty Shake supp only at dinner. Curr indicated a decreas lbs. The note furthe consuming 100% o refused x 2 days, co 50-100% at dinner, and current textures	nutritional assessment was included: weight has 30 days, on 7/25/18, the lement was changed to give ent weight 186 lbs. The note se in minimum weight; 180-190 er included; Resident is of breakfast in the last 3 days, onsumes 75-100% at lunch, no problems with swallowing s provided, no edema. Will kly. The assessment did not of fluid intake.					
	continued to be eat	e dated 8/14/18, indicated R56 ing and drinking well at meals dicators of dehydration.					
	8/17/18. The assess of the note was due fluctuating. The add the note included: " eating at a supervise plate, gripper mat, g ground up. His fluid receives Might Sha weight is 190-195 II encourage intake o followed monthly."	al assessment was dated sement indicated the purpose to the resident's weight ditional comments section of resident is on a regular diet, is sed table and uses a divided gets his meats chopped or ls continually improves. He ke at dinner daily. His goal bs. Staff continues to f food and fluids. He will be					
	R56's next nutrition	al note was dated 8/21/18,					

If continuation sheet Page 63 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI	E SURVEY PLETED
		245240	B. WING	i		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR			_	65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	indicated a weight of lbs. in one week, co weekly. R56's daily fluid rec reflected the followi 8/20/18: breakfast= refused lunch), dim (Total 780 cc) 8/21/18: breakfast= dinner=480 cc, dail 8/22/18: breakfast= breakfast), lunch 18 810 cc) 8/23/18: morning=1 dinner=300, daily fl 8/24/18: breakfast= 120 cc. (Total 580 c R56's surgery note reason for visit is to note indicated R56 general diet, and ha by a speech pathole the PEG tube had m months. The note fit pressure was low a communicated to th Manor to do more fit it was stable. R56's progress note was incontinent twid urine with hematuri would encourage fli further hematuria w until 8/28/18.	 a f 183.2 lbs., decrease of 2.8 bontinue to monitor weight b cord from 8/20-8/24/18 bing: a 370 cc, lunch=zero (resident her=290 cc, daily flush 120 cc. a 370 cc, lunch=180 cc, y flush 120 cc (Total 970 cc) a zero (resident does not want 80 cc, dinner=510 cc. (Total 970 cc) a l80 cc, lunch=370 cc, ush 120 cc (Total 970 cc) a 180 cc, lunch=370 cc, ush 120 cc (Total 970 cc) a 180 cc, lunch=160 cc, dinner 	F	692			

If continuation sheet Page 64 of 102

		AND HUMAN SERVICES			FORM): 12/28/2018 APPROVED). 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		245240	B. WING		11,	/02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	=	
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 692	intake totals after P continued to lack ev evaluation of daily f identify current hydr the PEG. 8/25/18: breakfast= dinner=340 cc. (Tot 8/26/18: breakfast= lunch resident does (Total 370 cc) 8/27/18: breakfast= dinner=280 cc. (Tot 8/28/18: breakfast= dinner=360 cc (tota R56's progress note was incontinent twic orange in color. 8/29/18: breakfast= does not want, noth 150 cc) 8/30/18: breakfast= lunch resident does (Total 360 cc) R56's progress note was not feeling well symptoms. A progre p.m. indicated no fu or concentrated urin well, and had no ince 8/31/18: breakfast= dinner=330. (Total 4 9/1/18: breakfast= z refused, nothing red cc)	PEG removal; the record vidence of comprehensive fluid intake, and failed to ration needs after removal of =180 cc, lunch=zero, tal 520 cc) =zero resident does not want, s not want, dinner 370 cc's. = 360 cc, lunch=zero, tal 640 cc) =360 cc, lunch=not recorded, al 720 cc) e on 8/28/18, indicated R56 ce with urine that was dark =150 cc's, lunch=zero resident hing recorded for dinner (Total =zero resident does not want, s not want, dinner=360 cc. e dated 8/30/18, indicated R56 I but demonstrated no outward ess note later that day at 3:35 urther concerns with hematuria ne, continued to drink fluids dicators of dehydration. =zero refused, lunch=160 cc,	F 692			

If continuation sheet Page 65 of 102

		AND HUMAN SERVICES				FORM): 12/28/2018 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		245240	B. WING			11,	/02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	dinner=zero refused 9/3/18: breakfast=3 recorded for dinner 9/4/18: breakfast=4 dinner 300 cc. (Tota R56's next nutrition an evaluation of the indicated a weight le 8/27/18, weight was 175.4 lbs., The note drink Ensure supple R56's record from 9 to reflect fluid defici Ensure supplement 9/5/18: breakfast=6 dinner=420 cc. (Tot 9/7/18: breakfast=4 refused, dinner 460 R56's progress note had cloudy urine wi fluids. R56's record reveal was conducted imm was removed (8/24 assessment indicat requirements was r to 2390 cc, indicatir cc/day, and was at even though, the da between 8/24 throu average liquid cons day. The assessme weight was 175.4 lb 128-161 lbs. Nutritio	d. (Total 420 cc) 60 cc, lunch=180 cc, nothing . (Total 540 cc) 20 cc, lunch=zero refused, al 720 cc) al note dated 9/4/18, lacked e daily fluid deficit, however, oss over the prior two weeks; s 181 lbs., 9/4/18, weight was e indicated R56 agreed to ement at all meals. 6/5 through 9/7/18, continued its even with the addition of t. 10 cc, lunch=190 cc, cal of 1220 cc) 20 cc, lunch zero resident 0 cc. (Total 880 cc) e dated 9/7/18, indicated R56 th no burning and to push led no nutritional assessment hediately after the PEG tube /18) until 9/7/18. The 9/7/18,	F	692			

Facility ID: 00701

If continuation sheet Page 66 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR		_	65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	nutritional supplement further indicated R& lunch often howeve Ensure, was walkin as much. The asse was a high nutrition reviewed weekly. R56's intake record continued to reflect nutritional assessm assessed fluid intak =2390 cc. On 9/8/18 the resid breakfast other=250 cc. (Total 850 cc) R56's progress note was having difficulty day; R56 told staff th hard time swallowin progress note indic again had a hard time eventually was able R56's intake 9/9/18 refused, lunch=zero (Total 300 cc) R56's progress note did not eat breakfas much for supper. A took his medication remembering how th R56's intake 9/10/1 lunch=190 cc, dinne	ent with meals. The note 56 was refusing dinner and er, was drinking 100% of ag more, and was not snacking assment further indicated R56 in risk-class 4, and weight was d from 9/8 through 9/11/18, if fluid deficits following the nent on 9/7/18. The total daily ke needs identified 9/7/18 dent's fluid intake included: 0 cc, lunch 420 cc, dinner 180 e dated 9/8/18, indicated R56 y swallowing his pills earlier in that he had been having a ng recently. A subsequent iated later that evening R56 me swallowing pills, however, e to get them down. B included: breakfast=zero to refused, dinner=300 cc. es from 9/9/18, indicated R56 st or lunch, and did not each a progress note indicated he in slowly like he was	F 692			

Facility ID: 00701

If continuation sheet Page 67 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	did not eat well for I slow to swallow wat progress notes indi the nurse practition to occasional period mouth, as well as n in past. In addition although R56 was e weight loss. R56's intake 9/11/1 lunch=zero residen (Total 140 cc) R56's progress note Provider Visit include verbalizing sore thro difficulty swallowing 4:00 p.m. indicated of attorney and inclu- and eating well for the verbalized sore thro assessment no note R56's nutritional as did not include a co- fluid intake. The ass weight on 9/10/18, pounds in one weel had been started w swallowing problem evaluated by speece R56's intake 9/12/1 refused, lunch=zero R56's progress note	breakfast or lunch and was ter and medications. The cated at 4:05 p.m. on 9/10/18, er (NP) was updated related ds of holding medications in not wanting as many snacks as the NP was informed that eating his meals, he had noted 8 included: breakfast 120 cc, t did not want, dinner 20 cc. es dated 9/11/18, from a ded: "past two days had been oat and had increased g at times." A progress note at a discussion with R56's power uded: "although is still drinking meals, past three days has bat at times although upon ed redness." sessment note from 9/11/18, omprehensive evaluation of sessment indicated R56's was 173.4 lbs., down two k. The note indicated Ensure ith meals, but R56 had some as noted so would be ch therapist. 8 included: breakfast=zero or refused, dinner=zero	F 6	92			

If continuation sheet Page 68 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	been complaining of suppository was giv large amount of sti assistance. Progres R56 was seen by M weight loss, periods concerns of constip R56's physician vis "He had a feeding to oral intake was mud discontinued. Rece well and has been of discomfort. Nursing constipation. He is has been in the pass indicated no qualify measurements, les been, and had activ assessment and pla his status is change seen and labs will b anything reversible R56's intake 9/13/1 lunch=zero refused there. R56's progress note indicated his physic transfer R56 to the intravenous fluids b "severe dehydratior R56's emergency d indicated nursing st intakes over the pa- ordered related to v	of abdominal discomfort, a ven and R56 expelled an extra icky stool that required digital as note at 4:09 p.m. indicated ID (medical doctor) related to so for refusing to eat, and recent bation: MD ordered labs. it note from 9/12/18, included: ube for many months but his ch better and the tube was ntly he has not been eating as complaining of abdominal g felt that this was related to much more sedated than he st." The physical exam ting data for vital signs and s alert than he previously has ve bowel sounds. The an included: "it is apparent that ed considerably since last be ordered to see if there is here." 8 included: breakfast=360 cc, 1, dinner= resident was not e dated 9/13/18, at 1:24 p.m. cian had called with orders to emergency room for because his lab work reflected	F	692			

If continuation sheet Page 69 of 102
		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	evaluation. The diag "dehydration." The dehydration." The dehydration/acute k from Lake Winona Patient had PEG tu unable to keep up f the patient presente between 99/61 and blood pressure imp further indicated the and had a distende of pain; imaging stu hospital admission. ears, nose, mouth, membranes. Labs of included: sodium of mg/dl (high), and C During an observat R56 laid in bed with assistant (NA)-G st morning cares how bed. NA-G stated s nutritional suppleme breakfast. During an observat R56 sat in his whee table. R56 stated ev PEG tube he had b constipation. During an interview registered nurse (R and drinking ok. RN assistants documer after each meal. RN if total daily fluid inta	gnosis that was given was notes included: kidney injury: patient was sent Manor for further evaluation. be removed on 8/24/18, likely luid needs. The note indicated ed with blood pressures after intravenous fluids given roved to 115/71. The note e patient reported constipation d abdomen with no complaints idy would be decided after Physical exam indicated and throat had dry mucous on 9/13/18, at 11:05 a.m. f 149 mEq/L (high), BUN 77 reatinine 2.42 mg/dl (high). ion on 10/31/18, at 7:55 a.m. n his eyes closed. Nursing ated she had already provided ever, R56 refused to get out of omebody would take him in a ent and offer him that for	F	592			

If continuation sheet Page 70 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	of fluid intake in orc could lead to dehyd a decrease in fluid i RN-J would encour the documentation interventions attem fluid deficit. RN-J w in urine integrity; RI not call the doctor u symptoms of urinar RN-J also stated it nursing judgement. During an interview stated R56 had bee the PEG tube; the r certain. RN-A state and R56 worked re could be removed. were monitored by the formula when h sustain daily recom RN-A stated the Os held on 7/30/18, wit a day until 7/30/18, decreased to 150 c reviewed R56's nut verified the record I assessment prior to PEG tube removal requirements. RN-/ lacked evidence of evaluations to deter the 9/7/18, nutrition identified R56 requi cc. RN-A stated prior R56 had seemed to had been. RN-A stated	der to ascertain deficits that Iration. RN-J stated if R56 had intake, or was not drinking, age fluids. RN-J further stated should indicate a deficit and pted or used to replace the vas asked about R56's change N-J stated usually they would unless there were three ry tract infection. However, would also be dependent on	F	592			

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			-	65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	hospitalization; so ti weren't accurate. R documentation rela integrity and indicat hematuria documer after a couple of da it may have been al physician and just p During an interview nutrition specialist (confirmed neither th dietary supervisor h comprehensive ass intake requirements the removal of the F assessment dated 9 intakes as documer nutrition progress n removal of the PEC daily fluid requirements tated she was uns evaluating daily fluid During an interview director of nursing (that nutritional asse completed prior to, the PEG removal, to requirements. The intakes should have evaluated daily. The facility's Hydrat 6/2017, indicated th factors for dehydrat are taken to determ sufficient fluid intake	he amounts entered probably N-A reviewed the ted to R56's change in urine ted although there was inted, the symptoms resolved by with no other symptoms, so ppropriate not to call the bush fluids. To n 11/1/18, at 10:23 a.m. (NS) reviewed the record and he registered dietian, nor had completed a sessment of R56's daily fluid s prior to, or immediately after, PEG. The NS said the 9/7/18 did not reflect fluid inted. The NS also verified totes prior to, and after 6 tube, lacked evaluation of ents and deficits. The NS also sure whether nursing was d intakes. Fon 11/1/18, at 11:42 p.m. (DON) stated the expectation essment should have been and/or immediately following	F	692			

If continuation sheet Page 72 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692 F 725 SS=E	following risk factor tube feedings, resid intake, diuretic use, disease, history of r intake, resident lack -Nursing assessme risk is assessed on needed thereafter. provider if dehydrat may be evaluated fi symptoms include: tenting of skinCard dehydration should assessment, appro interventions should assessment, appro interventions should The facility's Nutrition identified nutritional and/or identified card dehydration. Sufficient Nursing S CFR(s): 483.35(a) (§483.35(a) Sufficient The facility must hat the appropriate com provide nursing and resident safety and practicable physica well-being of each r resident assessment and considering the diagnoses of the fa accordance with the at §483.70(e). §483.35(a)(1) The f	s for dehydration: weight loss, dent dependent on staff for , cardiovascular agents, renal refusing fluids, limited fluid king sensation of thirst. ent: A) Residents' dehydration admission, quarterly, and as B) Nursing should update tion is suspected so resident urther. C) Some common thirst, dark urine, headache, re Plans: risk factors for be identified by nursing priate care plan and d be documented. on Risk Protocol dated 5/6/17, I risk categories, and included tegories of risk specific for Staff 1)(2)		725			12/11/18

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245240	B. WING		11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 725	nursing care to all r resident care plans (i) Except when wa this section, license (ii) Other nursing po- limited to nurse aid §483.35(a)(2) Exce paragraph (e) of thi designate a license nurse on each tour This REQUIREMEN by: Based on interview failed to ensure suf for the evening shif assistance with per resident's assessed R17, R3, R50, R82 need staff assistant (ADL). Findings include: R8's quarterly, Mini assessment dated	on a 24-hour basis to provide residents in accordance with ived under paragraph (e) of ed nurses; and ersonnel, including but not es. opt when waived under s section, the facility must ed nurse to serve as a charge	F 72	F725 The staffing guidelines in the fact assessment and staff schedule v revisited and updated by 11/30/2 residents on LVC. All licensed no staff and scheduling staff will be on staffing recommendations by 12/11/2018. Random audits of 5 residents weekly will be done by Worker or designee to determine feedback on staff response. All n will be brought to the QA/QI Com for further recommendations.	vere D18 for ursing nstructed a Social esults	
	cognition and need	, dated 8/9/18, indicated intact ed extensive assist with ADL.				
	cognition. R50's quarterly, ME	DS, dated 9/13/18, indicated intact				

If continuation sheet Page 74 of 102

	AND HUMAN SERVICES & MEDICAID SERVICES			F	NTED: 12/28/2018 ORM APPROVED 3 NO. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			3) DATE SURVEY COMPLETED
	245240	B. WING _			11/02/2018
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	CODE	
INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	
Continued From pa	ge 74	F 72	5		
R41's quarterly, MD intact cognition.	0S, dated 8/30/18, indicated				
RESIDENT INTER	/IEWS:				
10/31/18, at 10:59 a they forget to put yo you have to yell for mad at you for yellin R82, and R41 said reach their call light to them. R41 stated can't reach your cal time because they of waited 20 min, I had couldn't wait anymod didn't want to go in myself and I fell. Th months ago. I didn sore for a few days lot of people won't of any good anyways. them turning off our in these meetings a	a.m. R8 stated, sometimes bur call light on you and then help, then they (the staff) get ng for help. R8, R17, R3, R50, that they have been unable to because staff forgot to give it d, "What good will it do if you I light?" R82 stated, I fell one did not answer my call light, I d to go to the bathroom, I ore, I know I need help, but I my pants, so I tried to go his was during the day about 6 't get hurt bad, but I was sure . At 11:05 a.m. R43 stated, a complain because it doesn't do We have been talking about call lights for a long time now and it was never fixed, so why				
	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER INONA MANOR SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa R82's quarterly, ME intact cognition and ADL's. R41's quarterly, ME intact cognition and ADL's. R43's quarterly, ME intact cognition and toileting. R43's quarterly, ME intact cognition and ADL's. RESIDENT INTER R8 attended the res 10/31/18, at 10:59 at they forget to put yo you have to yell for mad at you for yellin R82, and R41 said reach their call light to them. R41 stated can't reach your cal time because they of waited 20 min, I had couldn't wait anymo didn't want to go in myself and I fell. Th months ago. I didn sore for a few days lot of people won't of any good anyways. them turning off our in these meetings at	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 R82's quarterly, MDS, dated 10/11/18, indicated intact cognition and needed extensive assist with ADL's. R41's quarterly, MDS, dated 8/30/18, indicated intact cognition. R49's quarterly, MDS, dated 9/13/18, indicated intact cognition and needed supervision with toileting. R43's quarterly, MDS, dated 8/30/18, indicated intact cognition and needed supervision with toileting. R43's quarterly, MDS, dated 8/30/18, indicated intact cognition and needed supervision with toileting.	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 245240 B. WING	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES OF DEFICIENCIES PE CORRECTION IDENTIFICATION NUMBER: DENTIFICATION NUMBER: 245240 B WING PROVIDER OR SUPPLIER INONA MANOR SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EF PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 R2's quarterly, MDS, dated 10/11/18, indicated intact cognition and needed extensive assist with ADL's. R41's quarterly, MDS, dated 8/30/18, indicated intact cognition and needed supervision with toileting. R43's quarterly, MDS, dated 8/30/18, indicated intact cognition and needed extensive assist with ADL's. RESIDENT INTERVIEWS: R6 attended the resident council meeting on 100/31/18, at 10:59 a.m. R8 stated, sometimes they forget to put your call light on you and then you have to yell for help. R8, T7, R3, R50, R82, and R41 said that they have been unable to reach their call light because staff forgot to give it to them. R41 stated, "What good will it do if you can't reach your call light?" R82 stated, 161 one time because they did not answer my call light, I waited 20 min, I had to go to the bathroom, I couldn't wait to go in my pants, so I tried to go myself and 1 fell. This was during the day about 6 months ago. I didn't get hurt bad, but I was sure sore for a few days. At 11:05 a.m. R43 stated, a lot of people wont complain because it doesn't do any good any	RS FOR MEDICARE & MEDICAID SERVICES OME OF DEFICIENCIES (11) PROVIDERSUPPLERICLIA IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A BUILDING 245240 B. WING (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE B& MING STREET ADDRESS, CITY, STATE, ZIP CODE INDAM MANOR STREET ADDRESS, CITY, STATE, ZIP CODE B& MING CONTROL OF CORRECTION INDAM MANOR STREET ADDRESS, CITY, STATE, ZIP CODE B& MING CONTROL OF CORRECTION INDAM MANOR STREET ADDRESS, CITY, STATE, ZIP CODE B& MING CONTROL OF CORRECTION INDAM MANOR STREET ADDRESS, CITY, STATE, ZIP CODE CONTROL OF CORRECTION CONTROL OF CORRECTION INDENDING STREET ADDRESS, CITY, STATE, ZIP CODE CONTROL OF CORRECTION CODE INDAM MANOR STREET ADDRESS, CITY, STATE, ZIP CODE CONTROL OF CORRECTION CONTROL OF CORRECTION INDENDING STREET ADDRESS, CITY, STATE, ZIP CODE CONTROL OF CORRECTION CONTROL OF CORRECTION CONTINUED STREET ADDRESS, CITY, STATE, ZIP CODE CONTROL OF CORRECTION CONTROL OF CORRECTION CONTINUED STREET ADDRESS, CITY, STAT

If continuation sheet Page 75 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	a.m. R17 stated, I h and asked, why are Several residents n At 11:07 a.m. 6 of 9 waited over an hour When asked what i wait for a response responded with: R4 stated over an hour hour and 45 minute if anyone had ever so long, R8, R17, R had. R82 stated, "I one answering my of the bathroom so ba during the evening their heads in agree R82, R41, R49, and worse on the evening stated, "We need m staffed." At 11:16 a. concern is when the seems like you sit t you need to get hel can get pretty sore. does get awful sore yes in agreement. STAFF INTERVIEV During interview on assistant (NA)-L sta work every fourth w me to stay late on t when we are short a changed a half hou court (LVC), we have we have 2 aides sc	have been yelled at by the staff e you turning on your light? nod their heads in agreement. 9 residents stated they have r for call light assistance. s the longest you have had to to the call light, they 43, R8, R17, R82, R3 all c. R50 stated, wait time was 1 es. At 11:10 p.m. when asked soiled their pants from waiting R3, R50, and R82 all said they felt deserted when I felt no call light when I had to go to ad." The worst staffing is shift, several residents nodded ement. R8, R17, R3, R50, d R43 said that staffing is ng shift. At 11:13 a.m. R82 nore help, we are too short .m. R8 stated, another ey put you on the toilet, it here for an hour, and when p to get off the toilet your butt R82 stated, "Yes your butt e!" R17, and R50 all nodded	F 7	725			

Facility ID: 00701

If continuation sheet Page 76 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	aides to work. This doesn't happen as a evening shift. I thin more of a schedulir it happens more on During interview on stated I have worked day shift. Staffing is shift, especially on school in the fall. I with call lights durin During phone interv NA- M stated, I wor every weekend I wo We are usually real weekends. As far a evenings after supp lights on at the sam to the bathroom and ideal is to have an e supper until we get help with our call lig have wet their pants to them. I bust my everybody, especia it for very long. I kr lights and we mean right away, but it isr bad, I am doing the a problem, sometim sometimes they cal late. So we end up weekends for sure week too. If we wa answered timely we	cheduled and we only have 3 s is when we are short. This often on day shift, mostly on ik our being short on staff is ng issue not a calling in issue, evening shift. 11/01/18, at 9:35 a.m. NA-O ed here 2 years, I work mostly s not good on the evening ce the college kids go back to have heard there was issues	F 7	725			

Facility ID: 00701

If continuation sheet Page 77 of 102

CENTER STATEMENT	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		FORM MB NO. (X3) DATE	12/28/2018 APPROVED 0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:				COM	PLETED
		245240	B. WING	_		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	lights after supper t bed. During interview on licensed practical n strictly day shift, we staffing during the of have 1 registered n trained medication a from other staff that call lights being ans they have been bro and this was maybe the call light wait tin concerns with staffi call lights. During interview on maintenance (M)-A persons on electrica have no way to run as when they go on off). During interview on director of nursing (issue with call lights being provided to th wetting their pants I answered timely, lo because resident di timely and tried to ta knowing she neede voicing complaints a THe DON stated, I treated with dignity The facility's Nurse	ime until we get everyone to 11/01/18, at 1:40 p.m. urse (LPN)-E stated, I work have no concerns with day. On evening shift they urse (RN) that floats, then aides and NA's. I have heard t there have been issues with swered during the evening, ught up at resident council, a couple months ago. I think he is the biggest concern, no ng on the day shift, just the 11/1/18, at 12:50 p.m. stated, I checked with al crew and at this time we reports on the call lights (such and when they are turned 11/01/18, at 4:39 p.m. the (DON) was informed of the s being answered without care he residents in need, residents because call light answered ake herself to the bathroom d assistance, and residents about being left on the toilet. want all my residents to be	F	725			

If continuation sheet Page 78 of 102

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA). 0938-039 TE SURVEY MPLETED
	ST CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		
		245240	B. WING			/02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 865 MANKATO AVENUE		
LAKE W	INONA MANOR			WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 725	meet the nursing c throughout the faci the nurse staff coo	ied nursing staff members to are needs of residents lity. The policy further indicated rdinator or charge nurse ss hours) will ensure there is a	F 725	5		
F 726 SS=D	CFR(s): 483.35(a)(§483.35 Nursing S The facility must ha the appropriate cor provide nursing an resident safety and practicable physica well-being of each resident assessme and considering the diagnoses of the fa accordance with th at §483.35(a)(3) The licensed nurses ha and skill sets nece needs, as identified assessments, and §483.35(a)(4) Prov limited to assessing implementing resid to resident's needs §483.35(c) Proficie The facility must en	(3)(4)(c) ervices ave sufficient nursing staff with mpetencies and skills sets to d related services to assure I attain or maintain the highest al, mental, and psychosocial resident, as determined by ents and individual plans of care e number, acuity and acility's resident population in e facility must ensure that ve the specific competencies ssary to care for residents' d through resident described in the plan of care.	F 726			12/26/18

If continuation sheet Page 79 of 102

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		3	· · ·	PLETED
		245240	B. WING		11/0	2/2018
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 726	Continued From pa	ige 79	F 726	3		
	This REQUIREMEN by: Based on observat review, the facility f knowledge, compet provide care, and re- individualized asset that promotes each nursing skills, infect of changes in cond well-being. This pra- registered nurses (Finding include: Refer to 880: RN-E hygiene after glove other areas had no and had not cleane dressing changes. hygiene after glove	described in the plan of care. NT is not met as evidenced tion, interview, and record ailed to ensure staff have the tencies and skill sets to espond to each resident's ssed needs safely in a manner of person centered care, basic tion control and identification ition, mental and psychosocial actice was evident for 2 of 2		F726 Standard work for Aseptic Dressing Changes was developed on 11/30/2 for licensed nursing staff. All licens staff will undergo competency testir compliance by 12/26/2018. 2 Rand audits of wound or dressing care wi performed weekly by a Nurse Mana designee. All results will be brough QA/QI Committee for further recommendations.	2018 ed ng of dom ill be ager or	
	the competencies of wound care. No con RN-D. During interview on	e provided for RN-E, however did not include pressure ulcer mpetencies were provided for 11/01/18, at 3:25 p.m., the confirmed RN-D and RN-E es as noted above.				
F 730	•	Review-12 hr/yr In-Service	F 730			12/11/18

If continuation sheet Page 80 of 102

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				3		
	PROVIDER OR SUPPLIER	245240	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	11/0	02/2018
	NONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 730	of every nurse aide months, and must j education based or reviews. In-service requirements of §4 This REQUIREMEN by: Based on interview failed to ensure and were conducted for E-3, E-4, and E-5) employed over 1 yea affect all residents potential to have in Findings include: An undated Employ employee (E-1) wa record lacked any e performance review greater than 10 yea E2 was hired 8/22/ lacked any evidence review had been co over two years ago E3 was hired 5/31/ lacked any evidence review had been co over a year ago. E4 was hired 5/10/ lacked any evidence	 and record reviews by a tleast once every 12 by orovide regular in-service by the outcome of these by training must comply with the 83.95(g). NT is not met as evidenced by and record review, the facility by and record reviews c of 5 employees (E-1, E-2, reviewed who had been bear. This had the potential to in the facility who had the teraction with these staff. yee Roster Report identified c hired 12/6/05, and employee evidence an annual c having been completed for ars. 16, and employee record bean annual performance by performance c an annual performance 	F 730	F730 An Annual performance review pro for nurse aides was developed an implemented 11/30/2018. All nur aides will receive an annual review mandatory competency labs durin calendar year. All nurse aids and management staff will be trained of annual review process by 12/11/20 The Staff Development Coordinate Designee will audit review complia biannually following the competen All results will be brought to the Q. Committee for further recommend	d se v during g the on 018. or or or or or or or cy labs. A/QI	

If continuation sheet Page 81 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 730 F 761 SS=E	lacked any evidenci review had been co was hired. During interview on the director of nursi don't do performance how do you know w you don't know thei DON stated, we do performance review progress." The DOI follow up as correct also reported the fa rounding monthly for formal rounding for employee progress documentation. A Performance Rev however was not re Label/Store Drugs a CFR(s): 483.45(g)(I §483.45(g) Labeling Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In ac Federal laws, the fa biologicals in locked	e an annual performance ompleted since the employee 11/01/18, at 5:08 p.m. when ing (DON) was asked, "if you ce evaluations on your staff, that training to provide them if r areas of weakness?" The not do formalized vs currently, "it is a work in N verfied staff receive verbal tions are necessary. The DON acility conducts leader or staff, which is a way to do all employees to verify , but don't maintain formal view Policy was requested, eceived. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nec with currently accepted oles, and include the	F 7				12/11/18

If continuation sheet Page 82 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245240	B. WING	·		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 761	locked, permanently storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa medications for 2 of and failed to ensure were removed from destroyed in a timel observed and 2 of 3 units. Findings include: On 10/31/18, 8:11 a leave a Humalog in a medications to anot LPN-C walked furth resident to see if sh 8:37 a.m. LPN-C re and prepared the im	access to the keys. Facility must provide separately y affixed compartments for d drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F	761	F761 Standard work for Medication Administration and Medication Expir Dates were reviewed on 11/29/18. <i>A</i> licensed staff and Trained Medicatio Assistants will be re-educated on the 12/11/2018. On 10/28/18 a review of medication storage areas, including medication carts, was completed an expired medications removed. A rar audit by the pharmacy consultant or designee will occur monthly on each 3 months for expired meds. 5 observations per week x 5 of medica administrations will be done by the N Manager or designee to monitor compliance of Expired Medication at Med Administration standard work. Nurse Manager or designee will com full review of medication expirations each unit monthly starting in 12/2018 results will be brought to the QA/QI Committee for further recommendat	All on ese by of ndom n unit x ation Nurse nd The nplete for 8. All	
	forget it." LPN-C sta	reminder so she "doesn't ated "I thought it was okay nave a needle when it's sitting					

Facility ID: 00701

If continuation sheet Page 83 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From pa there."	ge 83	F7	761			
	was interviewed on expected that all pe administering media	ector of nursing (DON) who 11/01/18, 1:37 p.m. it was ersons responsible for cations would keep a secure locked area when					
	and the Lakeview C cart a vial of Refres drop) was found wit September/2019 was September 11 writte to whether that was open or of when the disposed. LPN-D the overflow storage to	0 p.m. while observing LPN-D Court (LC) North medication th Tears (a moisturizing eye th an expiration date of as found but the label had en on it. LPN-D was unsure as the date when the bottle was e eye drop should be then went to the medication get a different bottle. The ed with was marked as having ember 12, 2018.					
	for various medicat drops are considere opened. This docur	ument listing expiration dates ions used in the facility, all eye ed expired 28 days after being nent is available on all cording to a note written of the					
	at the second floor hall. Another eye dr drops to treat eleva noted as being in th of the date it was of be okay for six mon Manufacturer instru should be disposed	30 a.m. LPN-B was observed medication cart for the south rop, Lumigan 0/01% (eye ted pressure in the eye) was he cart without documentation pen. LPN-B stated, "it should oths after opening." loction state that the medication of 4 weeks after opening. ame medication cart:					

If continuation sheet Page 84 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
LAKE W	NONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	-Artificial tears (lubr having been opener -Artificial tears with and no date opener -Ear drops 6.5% (ge wax) with no date o pharmacy 4/15/18. -Lantus insulin (a lo open date but mark to the facility on 9/2 good for 28 to 30 da removed the pen fro -Milk of Magnesia (f gastric upset or cor been opened 2/25/2 expiration date of 2 -Theragesic (a topic expiration date of 8 -Nystop 100,000 un the skin) with an ex On the same floor k observing TMA-B, a was found that was opened 2/28/18. Wi used, TMA-B stated months. "At end of surveyors and indic been disposed of bo Medication storage the LC unit was exa medication on 11/0 following were disco -Metoclopramide (a expired 8/3/18 -Sumatriptan succir	icating eye drops) marked as d 11/9/17 and expired 3/24/18 an expiration date of 8/10/18 d eneric ear drops to soften ear pened but delivered from the ong acting insulin) pen with no ted as having been delivered 8/18. LPN-B stated, "it is only ays after opening." LPN-B om the cart. mineral suspension given for nstipation) marked as having 2012 and with a pharmacy /25/2018. cal arthritis rub) with an /15/15 nits (an anti-fungal powder for piration date of 10/27/18 but the north cart, when a container of Artificial tears marked as having been hen asked if it could still be d, "I think they are good for 6 day, TMA-B found the ated that the eye drops had ecause, "they were expired." for over flow medication on amined with RN-F for expired 1/18, 7:53 a.m. and the overed: medication to treat heartburn)	F 7	761			

Facility ID: 00701

If continuation sheet Page 85 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 761	-Spironolactone (a blood-pressure) exp -Senexon (a bowel -Levothyroxine (a th 9/1/18 -Omeprazole (storn 9/15/18 -Losartan (for high l 8/14/18 -Triamcinolone (ste -Hydrophor 42% (m 9/14/18 -Refresh Liquidgel drops)opened 9/12/ -Citalopram (an ant -Acidophilus (probi expired 10/18 Following the findin medications, RN-F, unit was asked to e assures expired me RN-said she though supposed to be doi would notice expira administration shou The LC south medie expired medications LPN-C. The followin -Triamcinolone 0.1% triamcinolone 0.1% -Bisac-evac (bowel 7/2018 -Ventolin HFA AER the airways) expired	diuretic to treat high pired 10/29/18 stimulant) expired 10/23/18 hyroid medication) expired mach acid reducer) expired blood pressure) expired proid cream) expired 8/18/18 hoisturizing ointment) expired 1% (moisturizing eye /2018 tidepressant) expired 2/2/18 totics for gastric problems) g of the above expired nurse manager for the LC explain the facility process that edications are removed. In the PM shift TMAs were ng this but any nurse who tion dates during medication and "pull the medications". cation cart was examined for s on 11/01/18, 9:18 a.m. with ng were discovered: 5 expired 8/14/18 and expired 8/10/18 and expired 8/19/18 stimulant suppository) expired (an inhaler to treat spasms in	F 7	761			

Facility ID: 00701

If continuation sheet Page 86 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/0	02/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	The Bluffview Trans medication cart was medications on 11/0 The following were -Atorvastatin (a lipio -Omeprazole 20 mg -Warfarin (an antico -Systane balance (r expired 7/2018 -Econazole 1% (and -Miconazole 2% (ar 8/27/18) The medication over was examined with following were disco -Ipratropium Bromid solution to treat bro - Biotene Dry Mouth 10/16/18 According to an inte 11/01/18, 1:37 p.m. all person administer checking expiration be looking before a are not." A facility provided d Medication Expiration 6/3/2016 includes th before administerin date. Multi-dose inf vaccinations must b date expires and in protocols in book of 30 days, 60 days.). titled Standard Wor	sitional Care Unit (TCU) s examined for expired 01/18, 11:11 a.m. with RN-G. discovered: d reducer) expired 8/12/18 g expired 6/17/18 oagulant) expired 6/16/18 moisturizing eye drops) tifungal cream) expired 5/2018 ntifungal cream) expired er flow store room for the TCU RN-G as well, and the	F 7	61			

Facility ID: 00701

If continuation sheet Page 87 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761 F 812 SS=E	information: Gather the expiration date. be dated and initiale 30-60 days depend A facility provided p and dated as having provided and includ Medications and de ensure their integrit Medications and biologica does not include inf monitor storage are Food Procurement, CFR(s): 483.60(i)(1 §483.60(i) Food saf The facility must - §483.60(i)(1) - Proc approved or consid state or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and foo (iii) This provision do from consuming foo §483.60(i)(2) - Store serve food in accord	 eye drops and be mindful of If a new bottle then it needs to ed (bottles expire between ing on medication. olicy titled Storage-General g been reviewed 6/12 was les the following information: evices shall be stored to y, stability, and effectiveness. ologicals will be stored so that sonnel have accessAll als must be secure. The policy formation on who should eas for expired medications. Store/Prepare/Serve-Sanitary)(2) fety requirements. e food from sources ered satisfactory by federal, rities. e food items obtained directly rs, subject to applicable State gulations. oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices. loes not procured by the facility. e, prepare, distribute and dance with professional 	F 7				12/11/18

If continuation sheet Page 88 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245240	B. WING _			11/(02/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	•	
LAKE W	INONA MANOR			865 MANKATO AVI WINONA, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	by: Based on observat review, the facility fr room trays for the s 5 of 5 room trays do observed during the Findings include: On 10/29/18, at 5:0 (NA)-D started to do second floor. Five r residents in rooms There were no cover included water, coff were no covers on oranges on any of t On 10/29/18, at 5:1 the beverages or the oranges had covers the room trays to the floor. NA-D verified covers. On 11/01/18, at 8:5 manager (CDM) stat trays are to be cover on Monday night the were not covered. We had brief meetint talked about the ex- leaves the dining ro a.m., the CDM verifi- policy to ensure all room trays. The LWM Meal Ser	 aion, interview and document ailed to ensure all items on supper meal were covered for elivered on the second floor e dining observation. 9 p.m. nursing assistant eliver room trays on the oom trays were served to 246, 248, 250, 252 and 243. The ensurement of the small dishes of mandarin 	F 81	F812 The Lake Wi policy was up tray practices Nursing staff policy by 12/ Manager or o trays weekly compliance.	inona Manor meal serv pdated to include stand s. All LWM Dietary and f will be educated on th 11/2018. The Dietary designee will audit 15 r x 5 weeks to monitor f All results will be brou ommittee for further ations.	dard d ne new room for	

If continuation sheet Page 89 of 102

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	. 0938-039 E SURVEY IPLETED
				G		
		245240	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	11/	02/2018
	PROVIDER OR SUPPLIER			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 812	rooms are able to f and have the tray of staff memberb. A	ill out a menu for that meal lelivered to them by a nursing All items that leave the dining st be covered including	F 81	2		
F 880 SS=F	Infection Prevention	n & Control	F 88	0		12/11/18
	infection preventior designed to provide comfortable environ	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable				
	program. The facility must es	n prevention and control stablish an infection prevention m (IPCP) that must include, at owing elements:				
	reporting, investiga and communicable staff, volunteers, vi providing services arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards;				
	procedures for the but are not limited t (i) A system of surv possible communic	eillance designed to identify able diseases or ey can spread to other				

If continuation sheet Page 90 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	communicable dise reported; (iii) Standard and tr to be followed to pro (iv)When and how i resident; including k (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A sys identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review, the facility fa hygiene during a wo	ansmission-based precautions event spread of infections; solation should be used for a but not limited to: uration of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. etem for recording incidents facility's IPCP and the taken by the facility.	F 880	F880 Glucometer standard work updated 11/29/2018. Medication Administra Standard Work updated 11/29/2018	ition	

Facility ID: 00701

If continuation sheet Page 91 of 102

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED	
		245240	B. WING _		11/02/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 880	nebulizer equipmen of 1 residents (R37 on-going infection included comprehe infections that did r analysis of infection within the facility. T affect all 89 resider Also failed to ensur following medicatio (R67, R63 & R30) a glucometer. Findings include: HAND HYGIENE: R33 was observed receive a pressure by registered nurse hands, applied glow bed (R33 laid on ar had a visible large sacral wound on th from a sacral wound and left gluteal fold the sacral wound a applied clean glove measured the left g removed gloves. R four strips of carou bed, cut the strips of the right length, cor foam dressing and applied gloves, pla- gluteal wound, app	nt was cleaned after use for 1) and failed to establish an control program, which ensive surveillance of resident not require an antibiotic and ins to reduce the risk of spread his practice had potential to its residing in the facility. re hand hygiene was practiced on passes for 3 of 7 resident	F 88	,	d Care 18. All ed on the 18. 2 ssing care LWM Inee. 5 edication he LWM Inee to nt results will		

If continuation sheet Page 92 of 102

		AND HUMAN SERVICES				FORM	: 12/28/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	with the same soile Kleenexes, applied removed gloves. RI tubigrip on R33's le RN-H placed the so tray table, with no b scissors. RN-E rem the tray table and p dressing box on R3 of R33's room and utility room. During interview on stated she had not use or after use. RN washed hands at th after leaving R33's had not washed hand during the wound ca R34's current care p 10/29/18, Infection osteomyelitis, MRS Staphylococcus au During observations were the only perso (PPE) worn. No gov protect clothing fror wound care proced The Centers for Dis https://www.cdc.gov ecautions.html read is appropriate to the prevent soiling or co procedures and pat	e amount of secretions). RN-E d gloves on handed R33 two lotion to R33's arms, legs and N-E applied gloves, applied ft leg and removed gloves. biled scissors on top of R33's parrier underneath the noved the soiled scissors from laced the scissors into a t3's counter. RN-E walked out washed hands in the dirty 10/31/18, at 8:29 a.m., RN-E cleansed the scissors prior to N-E confirmed she had he start of the wound care and room. RN-E confirmed she nds between glove changes are. plan included problem, dated sacral wound related to A (Methicillin-resistant reus) and cellulitis. s of the wound care gloves onal protective equipment wn was worn by RN-E to m wound secretions during the	F	380			

If continuation sheet Page 93 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		245240	B. WING			11/0	02/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	excretions is anticip During interview on RN-G confirmed R3 sacral wound. Whe should wear during for R33's sacral wo drainage is not con should be followed. staff should gown. R1 was observed o receive dressing ch extremities by RN-I applied gloves, rem lower extremities (L moderate amount of both LE with wound gloves. RN-D applie Vaseline gauze pao scissors pulled out and applied 4 x 4 g over the Vaseline g Kerlix (cling wrap) a applied tubigrip to b scissors, washed th R1's bathroom, drie scissors back into th hands. During interview on RN-D verified had r glove changes durin both LE. RN-D verifisci sors prior to use and water after use During interview on	10/31/18, at 11:18 a.m., 33 had MRSA infection in n asked what PPE staff the wound dressing change und, RN-G stated unless the tained, standard precautions If there is excessive drainage, n 10/31/18, at 10:31 a.m., to anges to both lower D. RN-D washed hands, noved old dressings from both .E) (left LE dressing had of green drainage), cleansed d cleanser and removed ed gloves, applied 4 x 4 Is (cut the Vaseline gauze with of uniform pocket) to both LE, auze pad and abdominal pad auze, wrapped both LE with and removed gloves. RN-D both LE. RN-D picked up ne scissor in soapy water in ed the scissors and placed the uniform pocket. RN-D washed	F 8	80			

If continuation sheet Page 94 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING _			11/	02/2018
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				5 MANKATO AVENUE INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	expect handwashin NEBULIZER: R37 stated on 10/2 a respiratory proble with a cough that w facility staff started (pointing to nebulizer The nebulizer equip connected and had cup. During observation 7:18 a.m., nebulize R37's T.V. The mean moisture inside. At equipment remained During observation RN-H confirmed that together with moist RN-H stated we had as part of nursing s trained the equipment after each use, we once a week. RN-H in July. During interview on stated facility stand equipment after eact training was washir but staff should still after each use. That on. The facility Standar 8/9/18, directed wat	9/18, at 4:19 p.m., he has had em for a couple months now rill not go away. R37 stated using that thing over there er machine sitting on his bed). oment set on the bed, was fully moisture in the medication of R37's room on 10/31/18, at r equipment set on a stand by dication cup had visible 9:27 a.m., the nebulizer	F 88	80			

If continuation sheet Page 95 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	(one time per week SURVEILLANCE: During interview on nursing assistant (N up here on the sout stated she started in sores on her leg fro she was not aware her and another co- they were itching so scabies occurred m we found out reside members went to u The facility Monthly months of 5/18 thro sheets for 10/18 ind 5/18:1 pneumonia, without catheter 6/18: 1 UTI with cat wound 7/18: 1 pneumonia, without catheter 8/18: 1 upper respin UTI without catheter 9/18: 1 pneumonia, 10/18: 2 UTI withou presumed bronchiti There was no docu regarding scabies. During interview on stated I do not docu gather data for infer document as neede employees about co	 on Wednesdays. 10/31/18, at 10:23 a.m., NA)-A stated we had scabies th hall (second floor). NA-A tching like crazy and had open om the scabies. NA-A stated the residents had scabies, as -worker had to find out why b badly. NA-A stated the hid-September. NA-A stated ents had scabies after staff rgent care. Infection Reports dated from bugh 9/18 and Antibiotic Use dicated the following: 2 urinary tract infection (UTI) theter, 1 conjunctivitis, 2 2 UTI with catheter, 1 UTI ratory, 2 UTI with catheter, 1 wound 1 UTI with catheter, 1 wound ut catheter, 2 cellulitis, 1 	Fε	380			

If continuation sheet Page 96 of 102

PRINTED: 12/28/2018

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245240	B. WING _			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKE W	INONA MANOR				65 MANKATO AVENUE /INONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	stated the facility ha month. RN-I stated information regardin action taken and ou information that ind facility had been tree (works by disrupting of lice and scabies stated the medical staff were offered tr The facility policy H indicated VI. Indicat perform hand hygie B. Before and after procedures. Althoug procedures, hand h and after removal is possibility of tears of Between care activi involving different b Foley/IV/wound/trac blood, body fluids of dressings. F. Before area after touching immediate environr The facility policy S 1/17, indicated II. P (PPE): PPE is worn contact with blood of Wear an impervious procedures and pat contact with blood, excretions is anticip	ted I do not track viruses. RN-I ad scabies in house last she had no documented ing surveillance of the scabies, utcome. RN-I provided icated 15 residents in the eated with Permethrin topical g the function of the neurons mites) for scabies. RN-I director was informed and the reatment. land Hygiene, dated 7/18, tions for hand hygiene: Always ene in the following situations. performing invasive gh gloves are worn for certain hygiene before donning gloves a necessary because of the or holes in the gloves. D. ities on the same patient body sites (care of ch). E. After contact with or excretions, or wound e exiting the patient's care the patient or the patient's ment. tandard Precautions, dated ersonal Protective Equipment of body fluids. B. Gowns 1. s gown to protect skin and ontamination of clothing during tient-care activities when body fluids, secretion or	F 8	80			

If continuation sheet Page 97 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				365 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	control program: 1. case finding and an assess infection co Prevention is the co identifying potential actions prevent unt process, which esta to respond to outbro cases of infection ro Reporting: 1. The ir will analyze and pre- infection control con R67 received medic pass on 10/31/18, 8 practical nurse (LPI to a medication car medications. LPN-C removed them, but upon removal. LPN medications for R6 cart, computer for co medication containe LPN-C then applied room and administer this, LPN-C again ro removed gloves an hygiene. LPN-C the administration on th R63 received medic when LPN-C was o medication cart after down the halls and injection for R63. L hygiene upon return preparing the insuli	Surveillance, prevention and Surveillance is the process of nalysis used to report and ncerns and to identify risks. 2. Dyprehensive process of risk and utilizing appropriate oward events. 3. Control is the ablishes for actions necessary eaks, clusters, or individual equiring isolation precautions. Infection Control Coordinator esent the surveillance data to mmittee and nursing leaders. Cations during a medication 3:13 a.m. when licensed N)-C was observed returning t after administering C was wearing gloves and failed to do hand hygiene I-C then proceeded to set up 7, touching the medication documentation, resident ers, and medication cups. d gloves and went to R67's ered medications. Following eturned to the medication cart, d failed to perform hand en documented the	F	380			

Facility ID: 00701

If continuation sheet Page 98 of 102

		AND HUMAN SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/(02/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR				65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	a needle to the pen to R63's room wher performed and glov administered and L medication cart, rer needle, returned the gloves. LPN-C then hygiene. R63 had a blood su 11:33 a.m. when LF performing a blood the observation, LP glucometer (a mack R63's room where r and applied gloves, alcohol and collecte finger with the gluco the soiled glucomet the medication cart barrier between the cart. Following this, did not perform han proper cleaning wip cleansing would ha glucometer remaine cart where medicati administration. R30 received media a.m. when LPN-C w medications and en having performed h gloves and adminis R30's gastric tube w Following these tas	a. Following this, LPN-C went re hand hygiene was ves applied. The insulin was PN-C then returned to the moved the contaminated e pen to the cart and removed in failed to perform hand ugar check done on 10/31/18, PN-C was observed sugar check on R63. During PN-C was noted to take the hine to check blood sugar) to nurse performed handwashing , cleansed R63's finger with ed a blood sample from R63's ometer. Then LPN-C carried ter from the room, returned to and set it down without any e soiled equipment and the , LPN-C removed gloves but not hygiene. LPN-C stated the bes were not available and ve to wait. The soiled ed on top of the medication ions are prepared for	F 8	\$80			

Facility ID: 00701

If continuation sheet Page 99 of 102

		AND HUMAN SERVICES			FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245240	B. WING		11/(02/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	During an interview LPN-C was asked whand hygiene when LPN-C said hand hy administering media different room, to "c about appropriate h hygiene, LPN-C sai remove gloves." LP facility provided free hand washing and s During the same int would clean the glu thoroughly three tim and then let it sit for after, LPN-C picked down the hall with it the nurses' station y between the counter while she got the ap LPN-C did not apply glucometer off and counter and surface not cleansed with th During an interview director of nursing (expect general prin be followed by plac surface from contar glucometers should At 11/01/18, 1:30 p. expectations related medication adminis hand hygiene should	on 10/31/18, 11:49 a.m. when it was appropriate to do a dministering medications. ygiene should be done before cations and if called to a do it again." When asked hand hygiene related to hand id, "I should be doing it when I PN-C also stated that the quent education related to she had received education. terview, LPN-C stated she cometer by wiping it nes with a disinfecting wipe r two minutes to dry. Shortly d up the glucometer and went t and set it on a counter near without providing a barrier er and the soiled glucometer ppropriate disinfecting wipes. y gloves, but wiped the returned it to the cart. The e of the medication cart were he disinfecting wipes.	F 88			

If continuation sheet Page 100 of 102

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/28/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245240	B. WING			11/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR					865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 100	F٤	380			
	A policy for handwa medication adminis none provided. A policy for glucome and a document title and dated 4/6/2017 instructs licensed p medication aides to prior to testing. Furt directs the user to in strip and to clean the Sani-Cloth/purple to and wash hands. A supplied by the faci NOVA StatStrip Blo Observation [COMF to perform stated: " Precautions Policy with soap and wate meter should be rea-	shing and glove use during tration was requested and eter cleaning was requested ed Standard Work-Chemstrips was supplied. This document ractical nurses and trained wash hands and apply gloves thermore, after testing it mmediately dispose of the test the entire meter with "Super op wipes" then remove gloves in additional document was lity titled, Winona Health od Glucose Meter Direct PETENCY]. The first two steps follow proper Standard Guidelines" and "wash hands r and put on gloves." Then the adied. The competency ould be changed for patient g, the competency directs that					
	the meter should be (Sani-clothe Plus. V then the meter to be to provide the proce glucometer with the use. The document a clean environmer equipment. The Centers for Dis health professionals and after direct con contact with blood of	e cleaned with "correct wipes Vipes wet not dripping)" and e stored. Both documents fail ess for correctly cleaning the e exception of which wipes to s do not address maintaining at in response to soiled sease Control recommend s practice hand hygiene before tact with a patient's skin, after or body fluids, after contact wironment and after glove					

If continuation sheet Page 101 of 102

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM): 12/28/2018 APPROVED). 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245240	B. WING		11	/02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE

Facility ID: 00701

		AND HUMAN SERVICES & MEDICAID SERVICES	-	F	2112020	FORM	12/03/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPI	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245240	B. WING			10/	30/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR						
				<u> </u>	WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K	000			
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio Lake Winona Mano compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National f	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, (or) was found not in a requirements for participation and at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY				٦	
	Health Care Fire In: State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145			EPOC		
	By email to: FM.HC.Inspections	@state.mn.us					
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						11/30/2018

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.

Contraction Contraction		AND HUMAN SERVICES			9		APPROVED
1	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLI		T	0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· · /		01 - MAIN BUILDING 01		PLETED
		245240	B. WING			10/3	30/2018
NAME OF F	PROVIDER OR SUPPLIER	4		S	IREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WI	NONA MANOR						
				VV	PROVIDER'S PLAN OF CORRECTIO	N	(NE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	К 0	00			
		RRECTION FOR EACH T INCLUDE ALL OF THE RMATION:		01			
	1. A description of w to correct the deficie	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		title of the person ection and monitoring to nce of the deficiency.					
	basement. The build different times. The constructed in 1962 be of Type II(111) co was constructed to determined to be of Because the 1962 a 2000 addition are of	d for existing buildings, the					
	fire alarm system w detection and space	sprinklered. The facility has a ith full corridor smoke es open to the corridors that is natic fire department					
	The facility has a ca census of 89 at the	apacity of 110 beds and had a time of the survey.					
K 211	NOT MET as evider		К 2	211			11/23/18

Facility ID: 00701

If continuation sheet Page 2 of 9

PRINTED: 12/03/2018

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245240	B. WING		10/3	30/2018
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Ε	
	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETIC DATE
K 211 SS=F	Continued From pa CFR(s): NFPA 101	ge 2	K 21	11		
	exit locations, and a with Chapter 7, and continuously mainta full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1.7 This REQUIREMEN by: The facility failed to (18/19.2.2 through 7.1.10.1) This deficient pract (89) the residents,	 vs, corridors, exit discharges, accesses are in accordance I the means of egress is ained free of all obstructions to mergency, unless modified by 8/19.2.11. 10.1 NT is not met as evidenced o comply with Life Safety Code 18/19.2.11, 18.2.1, 19.2.1, ice could affect the safety of all staff and visitors within the 		K211- During walk-through of observed the Chapel Exit Doc force greater than 15# to oper door did not self-close and lat tested 1. The clearance on the Cha	or required a n and the ch when apel exit door	
	on 10/30/2018, obs revealed, or observ reviewed revealed to During walk-through	veen 09:30 AM and 12:30 PM ervations and staff interview ation and documentation the following: h of the facility observed the		 will be adjusted so that the do and closes with a force less th All other exit doors in the will be checked and adjusted that the door will open will less pounds of force and be able t the latched position. A quarterly security guard added include checking that a 	han 15#. facility that to ensure s than 15 o close to tour will be ill exit doors	
	15# to open and the latch when tested	equired a force greater than e door did not self-close and		 pull the doors closed to the la position and open door with le pounds of force. 4. The quarterly security guas he performed by the Security. 	ess than 15 ard tour will	
		ice was confirmed by the e Director at the time of		be performed by the Security monitored by the Facilities Op Manager, and report all defici EOC committee on the quarter 5. Work order #102296 was will be completed by Novemb	erations encies to the erly basis. created and	
	Protection - Other		K 30			11/12/18

	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			ATE SURVEY	
ID PLAN C				01 - MAIN BUILDING 01	10/30/2018	
			B. WING	1		
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR			٤			
(X4) ID PREFIX T A G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	Continued From pa CFR(s): NFPA 101	-	K 300			
	18.3 and 19.3 Prot not addressed by t deficient. This infor applicable Life Safe	KS section any LSC Section ection requirements that are he provided K-tags, but are mation, along with the ety Code or NFPA standard included on Form CMS-2567.				
	by:	NT is not met as evidenced o comply with Life Safety Code .5, 19.3.2.5.3(9)*)		K300- During walk-through of the facilit observed the stove located in the Physic	y cal	
		tice could affect the safety of all , staff and visitors within the nt/ Facility.		 Therapy Room did not have a power lock-out or disconnect 1. The Stove in the Physical Therapy room will be plugged into a power lock-of electrical receptacle 2. All other stove locations will be 	out	
	on 10/30/2018, obs revealed, or observ reviewed revealed	ween 09:30 AM and 12:30 PM servations and staff interview vation and documentation the following: h of the facility observed the		 audited for the use of a power lock-out disconnect. 3. New work procedures were implemented right away. Staff are required to use this every time. 4. The execution of the lock out 		
	stove located in the not have a power lo	e Physical Therapy Room did ock-out or disconnect		procedures will be added to the weekly safety rounding checks. This will audit the staff are locking up the lock after use.		
12 0 4 4	Facility Maintenance discovery.	cice was confirmed by the confirmed by t	14 0 4 4	5. Work order #102296 was created a was completed on November 12th, 201		
K 341	Fire Alarm System CFR(s): NFPA 101	- installation	K 341		11/0/10	

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION	MB NO.		
		. ,	G 01 - MAIN BUILDING 01	COMPLETED 10/30/2018			
		B. WING					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
				865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
K 341	Continued From page 4 Fire Alarm System - Installation A fire alarm System is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8		K 34				
	by: The facility failed to (18.3.4.1, 19.3.4.1) This deficient pract (89) the residents, smoke compartment Findings Include: On facility tour betw on 10/30/2018, obs revealed, or observ reviewed revealed to During walk-throug cover plate missing	ice could affect the safety of all staff and visitors within the nt/ Facility. ween 09:30 AM and 12:30 PM ervations and staff interview ration and documentation the following: h of the facility observed a from a fire alarm wiring the ceiling tile by Door 133		 K341- During walk-through of the observed a cover plate missing from alarm wiring junction-box above the ceiling tile by Door 133 1. The fire alarm junction box will receive the proper cover plate. 2. A campus wide audit has been to locate other junctions boxes with missing cover plates 3. Electrical contractors will be readed to follow all local, state, and federated. 4. All electrical contractors will be readed to follow all local, state, and federated. 4. All electrical contractors will be readed to follow all local, state, and federated. 5. Work order #102298 was created a cover plate was added on Nover 	om a fire le l n done h equired al codes. e closely k to des, l ated and		

Facility ID: 00701

If continuation sheet Page 5 of 9

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY	
ND PLAN (IDENTIFICATION NOWDER.		A, BUILDING	01 - MAIN BUILDING 01		
		245240	B. WING		10/30/2018	
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	E	
LAKE W	INONA MANOR		-	65 MANKATO AVENUE VINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 341	Continued From pa	ge 5	K 341			
	discovery.					
	Electrical Equipmer CFR(s): NFPA 101	nt - Other	K 919		11/12/18	
K 920 SS=F	Chapter 10, Electric that are not address but are deficient. The applicable Life Safe citation, should be in Chapter 10 (NFPA) This REQUIREMEN by: The facility failed to (Chapter 10 (NFPA) This deficient pract (89) the residents, smoke compartment Findings Include: On facility tour betwo on 10/30/2018, obs revealed, or observ reviewed revealed to During walk-through usage of triple-tap of following locations: 2nd FL - Nurses Sta This deficient practi Facility Maintenance discovery.	NT is not met as evidenced comply with Life Safety Code (99)) ce could affect the safety of all staff and visitors within the nt/ Facility. veen 09:30 AM and 12:30 PM ervations and staff interview ation and documentation he following: n of the facility observed the electrical outlet adapters in the 1st FL - adjacent to Door 123;	К 920	 K919- During walk-through of the facilit observed the usage of triple-tap electric outlet adapters in the following location 1st FL - adjacent to Door 123; 2nd FL - Nurses Station. All temporary triple-tap electrical outlet adapters were remove immediate 2. A campus wide audit has been don to locate other triple-tap electrical outlet adapters. Triple-tap electrical outlet adapters not be allowed in the facility. The use of triple-tap electrical outlet adapters will be added to the weekly safety rounding checks. Work order #102222 was created a all triple-tap electrical outlet adapters h been removed from the facility on November 12, 2018. 	cal s: ely. e t will ot	

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATI	NO. 0938-0391 DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDI	IG 01 - MAIN BUILDING 01		OMPLETED	
245240			B. WING			10/30/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
LAKE W	INONA MANOR			865 MANKATO AVENUE WINONA, MN 55987			
(X4) ID PREFIX T A G	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APP DEFICIENCY) DEFICIENCY)			HOULD BE	(X5) COMPLETION DATE		
K 920	Extension Cords Power strips in a para used for componen patient-care-related (PCREE) assemble by qualified personn 10.2.3.6. Power str may not be used for electronics), except rooms that do not u PCREE meet UL 13 strips for non-PCRE (outside of vicinity) care rooms, power standards. All power precautions. Exten substitute for fixed v Extension cords use immediately upon c which it was installe 10.2.4. 10.2.3.6 (NFPA 99), (NFPA 70), 590.3 (D This REQUIREMEN by: The facility failed to (10.2.4., 10.2.3.6 (I 400-8 (NFPA 70), 59 This deficient practi (89) the residents, smoke compartmer Findings Include: On facility tour betw on 10/30/2018, obset	atient care vicinity are only ts of movable l electrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity r non-PCREE (e.g., personal in long-term care resident se PCREE. Power strips for 363A or UL 60601-1. Power E in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general sion cords are not used as a wiring of a structure. ed temporarily are removed ompletion of the purpose for ed and meets the conditions of , 10.2.4 (NFPA 99), 400-8)) (NFPA 70), TIA 12-5 NT is not met as evidenced o comply with Life Safety Code NFPA 99), 10.2.4 (NFPA 99), 90.3(D) (NFPA 70), TIA 12-5) ce could affect the safety of all staff and visitors within the nt/ Facility.	Κ 9	 K920- During walk-through of observed in the Dining Room an electrical cord being used permanent wiring. The electrical cord was mimmediately and an electrical added per code. A campus wide audit has to locate other electrical cord as permanent wiring. Staff will be retrained to f of electrical cords are only all temporary use (24 hours or left) 	/ T.V. Room as emoved outlet was been done s being used ollow the rule owed for		

Facility ID: 00701

If continuation sheet Page 7 of 9

PRINTED: 12/03/2018

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039
ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING	01 - MAIN BUILDING 01	COMPLETED		
		245240	B. WING		10/:	30/2018
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE WINONA MANOR				865 MANKATO AVENUE WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIC DATE
K 920	Continued From pa	ge 7	K 920			
	During walk-through of the facility observed in the Dining Room / T.V. Room an electrical cord being used as permanent wiring			 should never be used for permanent use 4. The misuse use of all electrical cords will be added to the weekly safety rounding checks. 5. Work order #102301 was created an 		
		ice was confirmed by the e Director at the time of		the electrical cords has been reme and a new outlet for the TV was a November 12, 2018.		
	Gas Equipment - C CFR(s): NFPA 101	ylinder and Container Storag	K 923			12/11/18
	Greater than or equ Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cu Storage locations a	re outdoors in an enclosure or				
	limited- combustible gates outdoors) that gases are not store separated from cor sprinklered) or end	interior space of non- or e construction, with door (or it can be secured. Oxidizing id with flammables, and are nbustibles by 20 feet (5 feet if osed in a cabinet of nstruction having a minimum in rating				
	Less than or equal In a single smoke of cylinders available care areas with an or equal to 300 cub stored in an enclos					
	A precautionary sig each door or gate of where the sign inclu	n readable from 5 feet is on of a cylinder storage room, udes the wording as a N: OXIDIZING GAS(ES)				

Facility ID: 00701

If continuation sheet Page 8 of 9

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /				SURVEY PLETED
		245240	B. WING			10/3	30/2018
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE W	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 PREFI) TAG				(X5) COMPLETION DATE
К 923	of which they are re Empty cylinders are cylinders. When fa integral pressure ga considered empty is are marked to avoid in the open are prod 11.3.1, 11.3.2, 11.3. This REQUIREMEN by: The facility failed to (5.1.3.3.2 and 5.1.3) This deficient practi (89) the residents, smoke compartmen Findings Include: On facility tour betw on 10/30/2018, obs revealed, or observ reviewed revealed to During walk-through mixed storage of cy signage in the Oxyg This deficient practi	so cylinders are used in order eceived from the supplier. e segregated from full cility employs cylinders with auge, a threshold pressure s established. Empty cylinders d confusion. Cylinders stored tected from weather. 3, 11.3.4, 11.6.5 (NFPA 99) NT is not met as evidenced b comply with Life Safety Code 3.3.3.) ce could affect the safety of all staff and visitors within the nt/ Facility.	К 9	923	K923- Oxygen Full/Empty signage placed in Oxygen storage room by 11/28/18. Facilities and nursing stat be updated on new storage signage 12/11/2018. Random storage audit compliance will be performed week Health Unit Coordinator or designe weeks to monitor compliance. Rest be brought to the QA/QI for further recommendations.	ff will e by ts for tly by a e x 5	

If continuation sheet Page 9 of 9

PRINTED: 12/03/2018