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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XGD0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00701

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date : JGary Nederhoff, Unit Supervisor 03/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date: Kamala Fiske-Downing, Enforcement Specialist 03/13/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245240
March 13, 2018

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

Dear Ms. Hoeg:

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

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

Effective February 11, 2018 the above facility is certified for:

110 Skilled Nursing Facility/Nursing Facility Bed

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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 13, 2018

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

RE: Project Number S5240028

Dear Ms. Hoeg:

On January 24, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 11, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 10, 2018, effective February 11, 2018 and therefore remedies outlined in our letter to you dated January 24, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XGD0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00701

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245240**
2.STATE VENDOR OR MEDICAID NO.
(L2) **020945700**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/10/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
04/30

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

12.Total Facility Beds **110** (L18)
13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 02/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 02/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
January 24, 2018

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

RE: Project Number S5240028

Dear Ms. Hoeg:

On January 10, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 19, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 19, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 10, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 10, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING _____ B. WING _____	01/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted January 7, 8, 9, & 10, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On January 7, 8, 9, & 10, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 574		2/11/18

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

Electronically Signed | 02/01/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING _____ B. WING _____	01/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of	F 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING _____ B. WING _____	01/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 2 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide information to 5 of 5 residents (R56, R66, R156, R92, R93) who attended the resident council group meeting regarding the Ombudsman services as advocates for residents residing in the facility. This had the potential to affect all 106 residents residing in the facility. Findings include: During the resident group meeting held on 1/9/18, at 1:00 p.m. with state surveyor. R56, R66, R156, R92, and R93 were in attendance. On asking R56, R66, R156, R92, and R93 about the Ombudsman function as an advocate service and if they had access to the Ombudsman telephone number, they all said they were not aware of the Ombudsman nor services they provided, also not	F 574	Lake Winona Manor (LWM) reassigned the staffing hours posting to another location, eliminating the concealment of contact information on 1/29/18. LWM also updated the existing contact information provided on the same bulletin board with the Ombudsman name on this date for all residents. Scripting was added to the Resident Council Meeting agenda to reference external agency contacts, and given to the residents at the Resident Council Meeting dated 1/31/2018. A Social Worker met individually with residents in the sample (R56, R66, R156, R92, R93) who were unable to attend resident council. LWM staff education will be provided regarding MDH and Ombudsman contact	

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	245240	A. BUILDING _____ B. WING _____	01/10/2018

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F 574	Continued From page 3 aware to find the number to call the Ombudsman if needed. During observation on 1/10/18, at 10:00 a.m., Ombudsman information was found on the Resident's Right poster located on the short term care unit's bulletin board, it had been covered with the staffing hours. Also it lacked the Ombudsman's name. During interview on 1/10/18, at 1:44 p.m., with social services (SS)-A stated we have it post by the elevator on shortly term stay unit. SS-A then said the location and function of the Ombudsman is gone over in resident council when they discuss "Rights." In addition SS-A said the Ombudsman phone number is included in the "Resident's Right " book given to all residents on admission. Review of the resident council minutes for September, October, November and December 2017, had been reviewed and no "Rights" regarding Ombudsman was found on the forms.	F 574	information by 2/11/2018. The Social Worker or designee will audit the resident council meeting x 2 months to ensure compliance. Results will be reported to the QA&I Committee for further action.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		2/11/18

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F 580	Continued From page 4 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 580	The provider for R90 was updated on	

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F 580	Continued From page 5 review, the facility failed to notify physician timely regarding frequent refusals of psychoactive and psychotropic medication for 1 of 1 resident (R90) reviewed. Finding include: R90's significant change Minimum Data Set (MDS) and assessment dated 12/14/17 indicates no use of antipsychotic or mood altering medications. R90 had a Brief Interview Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment and a behavior of rejection of cares such as refusal of mediations. Review of care plan, no date, reads safety at risk; staff to be alert to any real or potential situations. Intervene in order to eliminate safety risks, administer medications as ordered. Review of physician orders signed dated 12/14/17, included for R90 currently taking Flomax (used for prostate), Tylenol as needed for pain and Senokot S for constipation. Nursing home note dated 12/14/17, reads "none" to psychotropic mediation usage or behaviors. A form titled Physician orders (orders to be signed by physician) dated 12/15/17 at 9:31 a.m. wrote by a registered nurse indicates a verbal order for Risperdal (antipsychotic) 1 mg by mouth every day for delusions following readmission to facility from a psychiatric hospital stay. A second admission to psychiatric hospital on 12/22/17, due to refusing medications, having delusions, and attempts to elope. R90 returned to facility on 1/2/18, this was found on a progress note. Review of R90's medication administration record for January 2018, showed refusals on 1/3/18,	F 580	medication refusals on 1/11/18. LWM reviewed and updated our medication policy and standard work on 1/30/2108 to clarify reporting procedure for resident refusals. Education will be provided to nursing staff by 2/11/18. Audits of resident medication refusals will be performed 3 x per week for 5 weeks by a Gemba Coordinator of Designee to ensure compliance. Results will be reported to the QA&I Committee for further action.	

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F 580	Continued From page 6	F 580		

1/6/18, 1/7/18, 1/8/18 and 1/9/18 for risperidone (antipsychotic) prescribed for agitation/hallucinations and to be give three times a day, gabapentin (anticonvulsant and miscellaneous uses such as neuropathic pain and peripheral neuropathy) prescribed for anxiety and pain was to be given four times a day, and venlafaxine (antidepressant) prescribed for depression and was to be given daily.

Interview on 1/10/18 at 11:00 a.m. with Licensed Practical Nurse (LPN)-A stated R90 refuses medication a lot and she will alert the registered nurse (RN) on duty when refusals occur. Then the RN will alert the physician of refusals. LPN-A stated R90 refused all medications today, and had refused several days in a row. LPN-A said when she gave the medications this a.m. R90 said, "I'm not taking them anymore." LPN-A then said that R90 was nice about the refusal and had just spent time in the Grace Unit and could be an issue if R90 is not taking his medications.

Interview on 1/10/18 at 11:09 a.m. RN-B stated the procedure for mediation refusals depends on the what kind of medication is being refused. RN- B stated it is the responsibly of each nurse to write a note to the physician. The facility has a notification book used to alert and give updates to the visiting physician. A certified nurse practitioner and or a medical doctor is in the facility to review notes and or see the residents two to three times a week or an on-call physician may be called anytime, RN-B added. RN-B stated the nurse, which was on duty the night before (1/9/18) left a note alerting the physician of R90 medication refusal. RN-B stated the physician is not due to be in the facility until 1/11/18. RN-B stated R90 has not been having increased behaviors except

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F 580	Continued From page 7 for the refusals of medications. Interview on 1/10/18 at 12:00 p.m. with director of nursing (DON) regarding expectation and procedure of staff when residents refuse medications. DON expect staff to use clinical judgement and may depend on the medication. DON stated would expect staff to update physician if two days passed and a resident refused medications. DON stated there was medications started and or adjusted while R90 was at the Grace Unit. Surveyor updated DON although R90 had five days with refusals of taking medication prescribed from the Grace Unit, no physician was updated and was not due to be updated until the next day.	F 580		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement the wanderguard to prevent elopement for 1 of 1 resident (R90) reviewed for accidents and assessed to need a wanderguard device when independently ambulating in the facility. Finding include:	F 689	A wanderguard was applied to resident R90□s cane on 1/10/18. No other residents have required a wanderguard since 1/10/18. Education regarding wanderguard use will be provided to nursing staff by 2/11/2018. Audits of appropriate wanderguard placement will be performed 1 x per week	2/11/18

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F 689	Continued From page 8 R90's significant change Minimum Data Set (MDS) an assessment dated 12/14/17, had a Brief Interview Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment and a worsening in behavior of wondering into potentially dangerous places such as outside the facility. Activities of daily living indicates he is independent with cares but needs supervision to walk in the corridor using mobility devices such as cane/crutch/walker. The MDS indicates the use of an alarm (an alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected) for wandering/elopement. Care area assessment (CAA) dated 12/18/17, reads wander guard is attached to his walker, independent with a cane at beginning of shift. Review of R90's care plan with problem dated 11/3/17, reads safety at risk; staff to be alert to any real or potential situations. Intervene in order to eliminate safety risks, wander guard in place, monitor placement and function twice daily or more. During interview on 1/9/18, at 10:19 a.m. with nursing assistant (NA)-D regarding the wonderguard. NA-D said that R90 mostly uses the cane and not so much the walker. The wanderguard was noted to be placed on the walker and not the cane. Progress notes dated 10/25/17-1/10/18 included several attempts to exit the building. Notes indicate R90 used his cane or walker. Progress note dated 1/9/18, at 12:35 p.m. reads, "[R90] did come out and walk in the hallway and was noted to be dressed in clean, well-fitted clothes and	F 689	for 5 weeks by a Gemba Coordinator or Designee to ensure compliance. Results will be reported to the QA&I Committee for further action.	

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F 689	Continued From page 9	F 689		

looked very nice. Several staff did tell him so. He was noted to be walking without his walker or cane, so writer retrieved his cane for him, did accept it, and began walking with it."

On 1/10/18, at 10:34 a.m. NA-D stated R90 tried to go outside according to the incident on 1/9/18. NA-D verified there the wanderguard is only located on the walker, so if he chooses to use the cane or no walking device there is not wanderguard.

Interview with registered nurse (RN)-B on 1/10/18, at 11:09 a.m. stated R90 is very mobile, wander guard was an intervention to prevent elopement, however, R90 refused to have on person so it was placed on the walker. Even though R90 uses the cane the majority of time he ambulates.

Interview with director of nursing (DON) on 1/10/18, at 12:00 p.m. and was asked regarding preventative elopement interventions for R90. DON said the staff are to redirect, wander guard is placed but R90 will not allow on his body. DON was informed the wanderguard is located on the walker and R90 chooses to use cane. The DON said this is a concern.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/01/2018

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Winona Manor is a 2-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1962 and 1964 was determined to be of Type II(111) construction. In 2000, addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the 1962 and 1964 buildings and the 2000 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 110 beds and had a census of 106 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 106 of 106 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through	K 712	Lake Winona Manor updated the Fire Alarm Drill Schedule and Observer locations by 1/18/2018. Facilities staff were trained on the updates by 1/24/2018. The Facilities Director or designee will audit compliance monthly x 12 to ensure compliance.	1/24/18

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K 712	Continued From page 3 19.7.1.7. FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 01/09/2018, documentation was not available to review to indicate that fire drills were conducted in the Nursing Home during the 3rd quarter evening and night shift and also during the 4th quarter evening and night shift. This deficient practice was verified by the Facility Maintenance Director.	K 712		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	K 914		1/24/18

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K 914	Continued From page 4 This REQUIREMENT is not met as evidenced by: Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This deficient practice could effect 106 out of 106 residents. FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 01/09/2018, documentation was not available to review to indicated that the electrical receptacles had received that following inspections: 1.The physical integrity of each receptacle shall be confirmed by visual inspection. 2. The continuity of the grounding circuit in each electrical receptacle shall be verified. 3. Correct polarity of the hot and neutral connections in each electrical receptacle shall be	K 914	Lake Winona Manor updated the comprehensive Preventative Maintenance (PM) software to test all receptacles in patient/resident care rooms 1/24/2018. The tracking process for annual electrical receptacle inspections was also updated 1/24/18. Facilities staff were trained on the updates 1/24/2018. The Facilities Director or designee will audit electrical receptacle inspections annually for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245240	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/09/2018**

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

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K 914	Continued From page 5 confirmed. 4. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). This deficient practice was verified by the Facility Maintenance Director.	K 914		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923		2/11/18

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	245240	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/09/2018**

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K 923	Continued From page 6 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 5.1.3.3.2 (NFPA 99). Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923	Lake Winona Manor added proper storage carts to accommodate current oxygen cylinders by 1/10/18. Staff education on proper storage will be provided by 2/11/18. The Gemba Coordinator or Designee will audit the Oxygen Storage room weekly x 8 to ensure compliance. Results will be reported back to the QA Committee for further action.	

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K 923	Continued From page 7 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99). This deficient practice could effect 106 of the 106 residents. FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 01/09/2018, 3 oxygen cylinders were observed unsecured or chained to prevent them from falling in the 2nd floor Oxygen Tank Storage Room. This deficient practice was verified by the Facility Maintenance Director.	K 923		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5240028

Dear Ms. Hoeg:

The above facility was surveyed on January 7, 2018 through January 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00701	A. BUILDING: _____ B. WING _____	01/10/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 7, 8, 9, & 10, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement the wanderguard to prevent elopement for 1 of 1 resident (R90) reviewed for accidents and assessed to need a wanderguard device when independently ambulating in the facility. Finding include: R90's significant change Minimum Data Set (MDS) an assessment dated 12/14/17, had a Brief Interview Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment and a worsening in behavior of	2 830	A wanderguard was applied to resident R90□s can on 1/10/18. No other residents have required a wanderguard since 1/10/18. Education regarding wanderguard use will be provided to nursing staff by 2/11/2018. Audits of appropriate wanderguard placement will be performed 1 x per week for 5 weeks by a Gemba Coordinator or Designee to ensure compliance. Results will be reported to the QA&I Committee for further action.	2/11/18

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2 830	Continued From page 3	2 830		

wondering into potentially dangerous places such as outside the facility. Activities of daily living indicates he is independent with cares but needs supervision to walk in the corridor using mobility devices such as cane/crutch/walker. The MDS indicates the use of an alarm (an alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected) for wandering/elopement.

Care area assessment (CAA) dated 12/18/17, reads wander guard is attached to his walker, independent with a cane at beginning of shift.

Review of R90's care plan with problem dated 11/3/17, reads safety at risk; staff to be alert to any real or potential situations. Intervene in order to eliminate safety risks, wander guard in place, monitor placement and function twice daily or more.

During interview on 1/9/18, at 10:19 a.m. with nursing assistant (NA)-D regarding the wonderguard. NA-D said that R90 mostly uses the cane and not so much the walker. The wanderguard was noted to be placed on the walker and not the cane.

Progress notes dated 10/25/17-1/10/18 included several attempts to exit the building. Notes indicate R90 used his cane or walker. Progress note dated 1/9/18, at 12:35 p.m. reads, "[R90] did come out and walk in the hallway and was noted to be dressed in clean, well-fitted clothes and looked very nice. Several staff did tell him so. He was noted to be walking without his walker or cane, so writer retrieved his cane for him, did accept it, and began walking with it."

On 1/10/18, at 10:34 a.m. NA-D stated R90 tried

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2 830	Continued From page 4 to go outside according to the incident on 1/9/18. NA-D verified there the wanderguard is only located on the walker, so if he chooses to use the cane or no walking device there is not wanderguard. Interview with registered nurse (RN)-B on 1/10/18, at 11:09 a.m. stated R90 is very mobile, wander guard was an intervention to prevent elopement, however, R90 refused to have on person so it was placed on the walker. Even though R90 uses the cane the majority of time he ambulates. Interview with director of nursing (DON) on 1/10/18, at 12:00 p.m. and was asked regarding preventative elopement interventions for R90. DON said the staff are to redirect, wander guard is placed but R90 will not allow on his body. DON was informed the wanderguard is located on the walker and R90 chooses to use cane. The DON said this is a concern. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the need to provide assessed devices to prevent elopement. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		2/11/18

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21426	Continued From page 5 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure first and second step tuberculin skin testing (TST) were completed correctly for 3 of 5 residents (R84, R85, & R208) whose documents were reviewed for TB prevention practices. This had the potential to affect all 106 residents who resided in the facility. Findings include: R84's Face Sheet, identified an admission date of 10/26/17. The first TST was administered on 11/2/17, seven days after admission. R85's Face Sheet, identified an admission date of 10/12/17. The first TST was administered on 10/12/17, and there was no documentation of TST having been read. The second TST was administered on 10/22/17, and read on 10/24/17.	21426	Nursing staff will be provided education on the Policy and standard work regarding resident 1st and 2nd step Mantoux tests by 2/11/18 The Gemba Coordinator or Designee will audit admission Mantoux weekly x 8 weeks to monitor compliance. Results will be reported to the QA&I Committee for further action.	

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21426	Continued From page 6 R208's Face Sheet, identified an admission date of 11/18/17. The first TST was administered 11/18/17, and read on 11/20/17. The second TST was administered on 11/28/17, and no documentation of reading the results. On 12/22/17, first TST administered again and read on 12/24/17. Second TST due 1/3/18, and was not completed. During interview on 1/10/18, at 10:30 a.m., with registered nurse (RN)-A verified R84 received her TST on 11/2/17, seven days after admission and verified it should have been started within 72 hours after admission, also RN-A verified R85 missed having the first TST read. RN-A further verified R208's second step TST was administered on 11/28/17, and the results were not read. R208's TST series was started over on 12/22/17, with first step read on 12/24/17, and the second TST was due on 1/3/18, and had not been completed. RN-A said, "My expectation is for the licensed staff to be following the medication orders and to be giving the tuberculin tests as ordered and for them to read and document the TST's as indicated in each resident's medical record." The facility policy titled, "Mantoux Testing for Residents," revised 11/18, purpose is to screen for active tuberculosis infections. Residents will have a 2-step Mantoux process started within 72 hours of admission if he/she does not have one documented in his/her health record within the last 90 days, unless contraindicated. Mantoux must be administered by a licensed nurse. Facility policy titled, "Tuberculosis," revised 3/16, purpose is to reduce the risk for transmitting tuberculosis (TB) to health care workers, patients, residents, volunteers and visitors.	21426		

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21426	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of	21800		2/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00701	A. BUILDING: _____ B. WING _____	01/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21800	Continued From page 8 the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide information to 5 of 5 residents (R56, R66, R156, R92, R93) who attended the resident council group meeting regarding the Ombudsman services as advocates for residents residing in the facility. This had the potential to affect all 106 residents residing in the facility. Findings include: During the resident group meeting held on 1/9/18, at 1:00 p.m. with state surveyor. R56, R66, R156, R92, and R93 were in attendance. On asking R56, R66, R156, R92, and R93 about the Ombudsman function as an advocate service and if they had access to the Ombudsman telephone number, they all said they were not aware of the Ombudsman nor services they provided, also not aware to find the number to call the Ombudsman if needed. During observation on 1/10/18, at 10:00 a.m., Ombudsman information was found on the Resident's Right poster located on the short term care unit's bulletin board, it had been covered with the staffing hours. Also it lacked the Ombudsman's name.	21800	Lake Winona Manor (LWM) reassigned the staffing hours posting to another location, eliminating the concealment of contact information on 1/29/18. LWM also updated the existing contact information provided on the same bulletin board with the Ombudsman name on this date for all residents. Scripting was added to the Resident Council Meeting agenda to reference external agency contacts, and given to the residents at the Resident Council Meeting dated 1/31/2018. A Social Worker met individually with residents in the sample (R56, R66, R156, R92, R93) who were unable to attend resident council. LWM staff education will be provided regarding MDH and Ombudsman contact information by 2/11/2018. The Social Worker or designee will audit the resident council meeting x 2 months to ensure compliance. Results will be reported to the QA&I Committee for further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21800	Continued From page 9 During interview on 1/10/18, at 1:44 p.m., with social services (SS)-A stated we have it post by the elevator on shortly term stay unit. SS-A then said the location and function of the Ombudsman is gone over in resident council when they discuss "Rights." In addition SS-A said the Ombudsman phone number is included in the "Resident's Right " book given to all residents on admission. Review of the resident council minutes for September, October, November and December 2017, had been reviewed and no "Rights" regarding Ombudsman was found on the forms. SUGGESTED METHOD OF CORRECTION: The administrator/social service/director of nursing could in-service all staff on the resident's right to have access to ombudsman telephone number. Also to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		