



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 23, 2024

Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

RE: CCN: 245240
Cycle Start Date: March 12, 2024

Dear Administrator:

On April 15, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2024

Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

Re: Reinspection Results
Event ID: BMJD12

Dear Administrator:

On April 15, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2024

Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

RE: CCN: 245240
Cycle Start Date: March 12, 2024

Dear Administrator:

On March 12, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

Lake Winona Manor

March 25, 2024

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 12, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 12, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated

Lake Winona Manor

March 25, 2024

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by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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:

https://mdhprovidercontent.web.health.state.mn.us/ltr_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:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2024

Administrator
Lake Winona Manor
865 Mankato Avenue
Winona, MN 55987

Re: State Nursing Home Licensing Orders
Event ID: BMJD11

Dear Administrator:

The above facility was surveyed on March 7, 2024 through March 12, 2024 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Lake Winona Manor

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2024
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NAME OF PROVIDER OR SUPPLIER LAKE WINONA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 865 MANKATO AVENUE WINONA, MN 55987
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(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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 3/7/24, 3/11/24, and 3/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/29/24
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>they will be completed.</p> <p>The following complaints were reviewed: H52401414C (MN00100992), H52401562C (MN00101002), H52401560C (MN00100970), and H52401681C (MN00101475) with a licensing order issued at 1390.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p>	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 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		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		4/6/24

Minnesota Department of Health

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21390	<p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 1 resident (R1) observed during peri care and full body lift transfer.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 1/11/24, identified R1's diagnoses included non-traumatic brain dysfunction including dementia. MDS identified R1 was usually understood and usually able to understand others. However, the cognitive patterns indicated R1 was rarely or never understood and had severe cognitive impairment with fluctuating behaviors present. In addition, R1's MDS identified R1 was dependent on staff for all activities of daily living (ADL)'s.</p> <p>R1's care plan revised on 1/31/24, indicated R1 needed assist of 2 staff with toileting using a full body lift due to safety concerns with the use of the standing lift. Staff to provide peri hygiene and apply barrier cream with cares.</p> <p>During an observation on 3/7/24 at 12:59 p.m., nursing assistant (NA)-A and NA-B entered R1's room. Both NA-A and NA-B did not wash or sanitize hands upon entering the room, grabbed gloves, and put them on after pulling the full body lift into the room. NA-A and NA-B put transfer sling around R1 and transferred R1 from the Broda wheelchair to the commode. NA-A removed the soiled brief from between R1's legs while she was on the commode and pulled the commode into the middle of the room. NA-B began using wipes and removing bowel</p>	21390	<p>The Hand Hygiene Policy was reviewed for updates by 3/28/2024. Education with comprehension testing of proper hand hygiene and glove use will be required for all nursing staff by April 6th. All staff with incorrect responses on the compliance test will receive 1:1 training by the DON or designee. Hand hygiene audits by a Nurse Manager or designee will be completed for 5 care related tasks three shifts/week for 8 weeks to monitor compliance. Results of audits will be taken to the QA&I committee to determine if further action is necessary.</p>	

Minnesota Department of Health

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21390	<p>Continued From page 4</p> <p>movement from R1's bottom when R1 began to void on the floor. NA-B then removed her soiled gloves and put on new gloves without sanitizing or washing hands and pushed the commode with R1 back over the toilet in the bathroom. NA-A then grabbed some towels and cleaned the floor and continued to use the same gloves throughout cares, including putting a new brief on R1, transferring her back to her wheelchair from the commode, removing the transfer sling and brushing R1's hair. NA-A then removed her gloves and disposed of them in the trash before NA-B took the trash out of the bin, put in a new bag, removed her gloves and put them in the old bag and spun and knotted the old bag setting it aside by the door.</p> <p>During interview on 3/07/24, at 1:15 p.m., NA-A stated she should have washed or sanitized her hands when entering and or leaving a resident's room. NA-A stated she should have sanitized or washed her hands during cares or whenever she encountered any bodily fluids. NA-A verified she had not appropriately sanitized or washed hands during R1's cares but was unable to articulate why she hadn't.</p> <p>During an interview on 3/07/2024, at 1:16 p.m., NA-B stated she should have washed or sanitized her hands when she entered and exited R1's room and after changing her gloves. NA-B identified she had not washed or sanitized her hands when she had changed her gloves in the room and stated she "just hadn't thought about it".</p> <p>During an interview on 3/12/24 at 1:59 p.m., the director of nursing (DON) stated it was an expectation staff should wash or sanitize hands when entering and exiting residents' rooms and each time they moved from a dirty area to a clean</p>	21390		

Minnesota Department of Health

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21390	<p>Continued From page 5</p> <p>area. DON further stated staff were expected to perform hand hygiene with each glove change. The DON expressed all staff are expected to follow facility policy when it came to hand hygiene and infection control.</p> <p>The policy Hand Hygiene updated 9/2023, indicated good hand hygiene technique should be used to prevent the spread of infection. Several types of cleaning agents are available including surgical scrub preparations, antiseptic lotion soaps and alcohol-based sanitizers.</p> <p>Adequate hand hygiene facilities are available throughout the facility. Hand hygiene should occur:</p> <ul style="list-style-type: none"> -Before and after a work shift. -Before and after eating, drinking, or handling food. -After using the toilet; after hand contact with mouth and nasal secretions (cough, sneezes, ect.). -Before and after significant contact with any resident. -Before and after performing invasive procedures. Although gloves are worn for certain procedures, hand hygiene before donning gloves and after removal is necessary because of the possibility of tears or holes in the gloves. -Between care activities on the same resident involving different body sites (i.e. care of foley/IV/wound/trach). -After contact with wounds or mucous membranes, or items such as dressings, bed pans, collecting devices with may be contaminated with secretions, excretions, or blood. -When there is doubt about the possibility of hand contamination. 	21390		

Minnesota Department of Health

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21390	<p>Continued From page 6</p> <p>SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.</p> <p>Time Period for Correction: Twenty-one (21) days.</p>	21390		

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

PRINTED: 03/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2024
NAME OF PROVIDER OR SUPPLIER LAKE WINONA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 865 MANKATO AVENUE WINONA, MN 55987		
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F 000	<p>INITIAL COMMENTS</p> <p>On 3/7/24, 3/11/24, and 3/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H52401414C (MN00100992), H52401562C (MN00101002), H52401560C (MN00100970), and H52401681C (MN00101475) with a deficiency cited at F880.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000			
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p>	F 880		4/6/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/29/2024

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER LAKE WINONA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 865 MANKATO AVENUE WINONA, MN 55987		
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F 880	<p>Continued From page 1</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 880		

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F 880	<p>Continued From page 2</p> <p>contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 1 resident (R1) observed during peri care and full body lift transfer.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 1/11/24, identified R1's diagnoses included non-traumatic brain dysfunction including dementia. MDS identified R1 was usually understood and usually able to understand others. However, the cognitive patterns indicated R1 was rarely or never understood and had severe cognitive impairment with fluctuating behaviors present. In addition, R1's MDS identified R1 was dependent on staff for all activities of daily living (ADL)'s.</p>	F 880	<p>The Hand Hygiene Policy was reviewed for updates by 3/28/2024. Education with comprehension testing of proper hand hygiene and glove use will be required for all nursing staff by April 6th. All staff with incorrect responses on the compliance test will receive 1:1 training by the DON or designee. Hand hygiene audits by a Nurse Manager or designee will be completed for 5 care related tasks three shifts/week for 8 weeks to monitor compliance. Results of audits will be taken to the QA&I committee to determine if further action is necessary.</p>	

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F 880	<p>Continued From page 3</p> <p>R1's care plan revised on 1/31/24, indicated R1 needed assist of 2 staff with toileting using a full body lift due to safety concerns with the use of the standing lift. Staff to provide peri hygiene and apply barrier cream with cares.</p> <p>During an observation on 3/7/24 at 12:59 p.m., nursing assistant (NA)-A and NA-B entered R1's room. Both NA-A and NA-B did not wash or sanitize hands upon entering the room, grabbed gloves, and put them on after pulling the full body lift into the room. NA-A and NA-B put transfer sling around R1 and transferred R1 from the Broda wheelchair to the commode. NA-A removed the soiled brief from between R1's legs while she was on the commode and pulled the commode into the middle of the room. NA-B began using wipes and removing bowel movement from R1's bottom when R1 began to void on the floor. NA-B then removed her soiled gloves and put on new gloves without sanitizing or washing hands and pushed the commode with R1 back over the toilet in the bathroom. NA-A then grabbed some towels and cleaned the floor and continued to use the same gloves throughout cares, including putting a new brief on R1, transferring her back to her wheelchair from the commode, removing the transfer sling and brushing R1's hair. NA-A then removed her gloves and disposed of them in the trash before NA-B took the trash out of the bin, put in a new bag, removed her gloves and put them in the old bag and spun and knotted the old bag setting it aside by the door.</p> <p>During interview on 3/07/24, at 1:15 p.m., NA-A stated she should have washed or sanitized her hands when entering and or leaving a resident's room. NA-A stated she should have sanitized or</p>	F 880		

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F 880	<p>Continued From page 4</p> <p>washed her hands during cares or whenever she encountered any bodily fluids. NA-A verified she had not appropriately sanitized or washed hands during R1's cares but was unable to articulate why she hadn't.</p> <p>During an interview on 3/07/2024, at 1:16 p.m., NA-B stated she should have washed or sanitized her hands when she entered and exited R1's room and after changing her gloves. NA-B identified she had not washed or sanitized her hands when she had changed her gloves in the room and stated she "just hadn't thought about it".</p> <p>During an interview on 3/12/24 at 1:59 p.m., the director of nursing (DON) stated it was an expectation staff should wash or sanitize hands when entering and exiting residents' rooms and each time they moved from a dirty area to a clean area. DON further stated staff were expected to perform hand hygiene with each glove change. The DON expressed all staff are expected to follow facility policy when it came to hand hygiene and infection control.</p> <p>The policy Hand Hygiene updated 9/2023, indicated good hand hygiene technique should be used to prevent the spread of infection. Several types of cleaning agents are available including surgical scrub preparations, antiseptic lotion soaps and alcohol-based sanitizers.</p> <p>Adequate hand hygiene facilities are available throughout the facility. Hand hygiene should occur:</p> <ul style="list-style-type: none"> -Before and after a work shift. -Before and after eating, drinking, or handling food. -After using the toilet; after hand contact with 	F 880		

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F 880	Continued From page 5 mouth and nasal secretions (cough, sneezes, ect.). -Before and after significant contact with any resident. -Before and after performing invasive procedures. Although gloves are worn for certain procedures, hand hygiene before donning gloves and after removal is necessary because of the possibility of tears or holes in the gloves. -Between care activities on the same resident involving different body sites (i.e. care of foley/IV/wound/trach). -After contact with wounds or mucous membranes, or items such as dressings, bed pans, collecting devices with may be contaminated with secretions, excretions, or blood. -When there is doubt about the possibility of hand contamination.	F 880		