Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52409282M
Compliance #: H52407764C

Date Concluded: April 28, 2026

Name, Address, and County of Licensee Investigated:
Lake Winona Manor
865 Mankato Ave
Winona, MN 55987
Winona County

Facility Type: Nursing Home

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation: The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s): The alleged perpetrator (AP) neglected the resident when the resident was rolled out of bed during peri care, resulting in fractures to both of her legs.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although the resident rolled out of bed during peri care, the occasion was an isolated error. The resident sustained a right tibia and fibula fracture, and a distal end of left femur fracture. The facility sent the resident to the emergency department when she was treated with a splint and Tylenol and returned to the facility.

The investigator conducted interviews with facility staff members, including administrative staff, social worker, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, personnel files, staff schedules, policies, and procedures.

The resident resided in a nursing home facility. The resident's diagnoses multiple sclerosis and anxiety. The care plan indicated the resident had not ambulated for about 7 years. It is also

indicated the resident required assistance of one person for toileting and two persons with mobility and repositioning.

A concern arose when the resident accidentally rolled out of bed and ended up lying on her back on the floor, with her bilateral lower extremities toward the head of the bed and her head and upper body at the foot of the bed. The resident was transferred to the emergency department.

The emergency department documentation indicated the resident arrived after a fall and X-rays showed a right nondisplaced fracture of the proximal tibia and an impacted fracture of the right fibular neck. A splint was placed from the proximal thigh down to the foot and overlaid with Ace wraps. The resident was then transferred back to the facility.

During an interview, the resident stated she fell out of bed because AP did not wait for help and proceeded to roll her. She stated her bones were broken in both her right and left legs. She also stated prior to the fall, she had no control of her leg movements.

During an interview, the AP stated he was providing routine nightly care and began cleaning the resident that night. After finishing cleaning her front side, he activated the call light for a second staff member to assist with turning her so he could clean her back. While he waited, the resident became anxious for the cares to be completed. As the AP repositioned the resident, her legs began to slip off the bed. He put her legs back onto the bed in a position where he thought they would not slip again, but they slipped again. He stated the legs slipped so quickly he threw himself over the bed to prevent the resident from hitting the ground hard. The AP stated he did not have enough strength to hold her up, so he held onto her upper body to prevent her head from hitting the ground. The resident's legs fell to the floor, however the AP could not see whether her legs were bent. The AP stated the resident required one-person assistance with turning prior to the fall; however, after the fall, the resident's care plan was updated to require two assistants.

During an interview, a manager stated at the time of the fall, the resident's care plan indicated she required assistance of one person with toileting and assistance of two persons with turning, repositioning, and bed mobility. She stated after reviewing the record, she acknowledged the documentation appeared confusing regarding how many staff members were required to assist the resident. She further stated at the time of the fall, the AP activated the call light to request assistance and waited; however, the resident did not want to wait and asked him to proceed with cleaning her. The manager stated the AP was trying to meet the resident's needs while waiting for another caregiver to provide assistance.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means: An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The resident was assessed and transferred to the Emergency Room for further evaluation. An internal investigation was initiated. Staff were provided education regarding modifications to the resident’s care plan, and AP was provided education prior to returning to work. AP was no longer working directly with the resident. The facility’s care plans and care conference policy were revised.

Action taken by the Minnesota Department of Health: No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/06/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H52409282M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/06/2026**

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20000	Continued from page 1 receipt of the electronic documents.	20000		