MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Lake Winona Manor

Facility Address:
865 Mankato Avenue

Facility City:
Winona

State:	ZIP:	County:
Minnesota	55987	Winona

Report Number:
H5240016 and H5240017

Date of Visit:
January 3 and 4, 2017

Time of Visit:
12:15 p.m. to 5:15 p.m.
7:30 a.m. to 11:15 a.m.

Date Concluded:
April 25, 2017

Investigator's Name and Title:
Christie Bluhm, R.N., Special Investigator

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when the resident was left unattended while seated on an unlocked commode and suspended in the ceiling lift. The resident had a fall and suffered fractures to both legs.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect occurred when the facility staff left the resident unattended and unsupervised while attached to the ceiling lift, against manufacturer's guidelines. The resident had a fall and sustained bilateral leg fractures.

The resident had a history of stroke and congestive heart failure. The resident required assistance of two staff for toileting and bathing. The resident was non-weight bearing and required the use of the mechanical ceiling lift for transfers to and from bed, the chair, and the commode. The resident was alert and oriented. The use of a mechanical lift for transfers or level of supervision while the resident was seated on the commode was not specified in the resident's care plan.

On the day of the incident, the resident was being toileted by two facility staff. The mechanical ceiling lift was used to transfer the resident to the commode positioned in the middle of the resident's room. While seated on the commode, the resident used the wheelchair pedals for feet support and the ceiling lift bar for upper body arm support. Two staff assisted the resident into this position and then left the room to provide privacy which was the routine. The resident was still attached to the ceiling lift while on the commode. A short time later, facility staff heard the resident scream and immediately went to the resident's room. The resident was found suspended by the ceiling lift with the resident's buttocks touching the floor. The commode wheels were not locked, and the commode rolled away from the resident.

During the post fall assessment, the resident complained of severe pain. The resident refused evaluation at first, but family convinced the resident to be evaluated and accompanied the resident for x-rays in the emergency room. Imaging showed the resident suffered bilateral leg fractures. The resident refused transfer to the hospital for treatment and comfort care was initiated. The resident died several days later.

The resident's death certificate identified the resident's cause of death was related to complications of a stroke; blunt force trauma with fracture was a significant condition that contributed to the death.

When interviewed, the physician stated the resident's death was related to the fall.

The manufacturer's guidelines state, "Never leave a patient unattended in a lifting situation."

The facility immediately took action to ensure the safety of all residents. Focus discussions were held with staff on every shift to discuss the incident and safety implementation. Reminder labels were placed on all transfer devices and lifts that directed staying with the resident while connected to the transfer or lift device. Labels were placed on the receiving devices, commodes and wheelchairs, with reminders to lock the receiving device during the transfer. Staff education, with return competency requirements, was completed.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility failed to have a policy in place for staff to follow regarding supervision of residents while connected to the mechanical lift. The facility failed to follow the lift manufacturers guidelines for resident safety.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) 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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Treatment Sheets
- ☒ Care Plan Records
- ☒ Social Service Notes
- ☒ Skin Assessments
- ☒ Facility Incident Reports
- ☒ Activities Reports
- ☒ ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- ☒ Death Certificate

Additional facility records:

- ☒ Resident/Family Council Minutes
- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: Residents with lift transfers

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: 11

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify:

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Injury

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A
Was equipment being operated in safe manner: ○ Yes ◉ No ○ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Winona Police Department

Winona City Attorney

Winona County Attorney

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 _____	C 02/18/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5240016 and case #H5240017. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		

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

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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F 323	Continued From page 1 by: Based on interview and document review, the facility failed to supervise 1 of 4 residents (R1) when the resident fell while seated on the commode and connected to a mechanical lift. Findings include: R1's care plan dated 10/1/15, indicates an admission diagnosis of hemiplegia and hemiparesis following cerebral infarction. R1 required assistance with all aspects of mobility. The care plan also indicates R1 was able to make decisions related to her cares. The Quarterly Minimum Data Set (MDS) dated 10/27/16, indicated R1 was totally dependent for transfers and toileting. Progress notes dated 12/29/16 at 2:17 p.m., indicate R1 was toileted on the commode in her room. When staff entered the room, they found her with her bottom touching the floor but still connected to the ceiling lift. When R1 was asked if the commode slid out from under her, she responded yes. The commode chair was found unlocked. R1 had a skin tear on the left shin and complained of increased pain in the left knee. X-rays were ordered. Progress note dated 12/29/16 at 4:42 p.m. notes that a family member accompanied R1 for xrays and results showed both of R1's legs were fractured. During an interview on 1/3/17 at 2:15 p.m., CNA-B stated that R1 was transferred to the commode in the middle of the room and stayed in the sling connected to the lift while on the	F 323		

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F 323	Continued From page 2 commode. R1 was given the call light and staff left the room. This was R1's normal procedure. Per interview dated 1/3/17 at 2:44 p.m., CNA-E heard R1 scream and immediately went to the room. CNA-E saw R1 suspended in the lift sling with R1's bottom touching the floor. The commode was near the door and the wheels were not locked. When CNA-E was asked about supervision for R1, CNA-E stated that leaving R1 alone while on the commode was R1's privacy routine which could last up to thirty minutes. Per interview dated 1/4/17 at 9:37 a.m., RN-A stated that immediately after the fall, R1 complained of left leg pain. The provider was notified and x-rays were ordered. During this time, RN-A noted swelling in the right leg. R1 refused emergency room evaluation. It was difficult to get R1's pain under control. When RN-A was asked about leaving the resident unsupervised while still attached to the lift, RN-A stated that it became a comfort measure while seated on the commode but it was not reflected in the care plan. During interview on 1/4/17 at 10:10 a.m., the Director of Nursing stated that for R1, it was standard to use the commode in the middle of the room as the lift does not go into the bathroom. It appeared the commode was not locked based on the found position. The lift manufacturer's guidelines were researched and does not indicate whether it is alright to leave the resident unattended but suggests not to leave the resident alone in an upright position in the lift. During an interview on 1/13/17 at 2:30 p.m., CNA-F states the resident was toileted per her	F 323		

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F 323	Continued From page 3 routine. This routine included transferring R1 to the commode, giving R1 the hand controller for the lift and the call light. Staff then left the room to give the resident privacy. The physician was interviewed on 1/12/17 at 10:05 a.m. and stated R1 had refused further treatment after the fall. Comfort measures were initiated. The resident had a broken femur that occurred during the fall which caused significant swelling and pain in the leg. The resident was put on a morphine pump. R1 died several days later and the death was related to the fall. There was not a facility policy that specified the amount of supervision required related to mechanical lift connection while using the commode. The use of the mechanical lift for transfers or level of supervision while on the commode was not specified in the care plan.	F 323		

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	00701	A. BUILDING: _____ B. WING _____	C 02/18/2017

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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: A complaint investigation was conducted to investigate complaint #H5240016 and #H5240017. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin	2 000		

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2 000	Continued From page 1 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 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident was free from maltreatment when 1 of 4 residents (R1) fell while	21850		

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21850	Continued From page 2 seated on the commode and connected to a mechanical lift. Findings include: R1's care plan dated 10/1/15, indicates an admission diagnosis of hemiplegia and hemiparesis following cerebral infarction. R1 required assistance with all aspects of mobility. The care plan also indicates R1 was able to make decisions related to her cares. The Quarterly Minimum Data Set (MDS) dated 10/27/16, indicated R1 was totally dependent for transfers and toileting. Progress notes dated 12/29/16 at 2:17 p.m., indicate R1 was toileted on the commode in her room. When staff entered the room, they found her with her bottom touching the floor but still connected to the ceiling lift. When R1 was asked if the commode slid out from under her, she responded yes. The commode chair was found unlocked. R1 had a skin tear on the left shin and complained of increased pain in the left knee. X-rays were ordered. Progress note dated 12/29/16 at 4:42 p.m. notes that a family member accompanied R1 for xrays and results showed both of R1's legs were fractured. During an interview on 1/3/17 at 2:15 p.m., CNA-B stated that R1 was transferred to the commode in the middle of the room and stayed in the sling connected to the lift while on the commode. R1 was given the call light and staff left the room. This was R1's normal procedure. Per interview dated 1/3/17 at 2:44 p.m., CNA-E	21850		

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21850	Continued From page 3 heard R1 scream and immediately went to the room. CNA-E saw R1 suspended in the lift sling with R1's bottom touching the floor. The commode was near the door and the wheels were not locked. When CNA-E was asked about supervision for R1, CNA-E stated that leaving R1 alone while on the commode was R1's privacy routine which could last up to thirty minutes. Per interview dated 1/4/17 at 9:37 a.m., RN-A stated that immediately after the fall, R1 complained of left leg pain. The provider was notified and x-rays were ordered. During this time, RN-A noted swelling in the right leg. R1 refused emergency room evaluation. It was difficult to get R1's pain under control. When RN-A was asked about leaving the resident unsupervised while still attached to the lift, RN-A stated that it became a comfort measure while seated on the commode but it was not reflected in the care plan. During interview on 1/4/17 at 10:10 a.m., the Director of Nursing stated that for R1, it was standard to use the commode in the middle of the room as the lift does not go into the bathroom. It appeared the commode was not locked based on the found position. The lift manufacturer's guidelines were researched and does not indicate whether it is alright to leave the resident unattended but suggests not to leave the resident alone in an upright position in the lift. During an interview on 1/13/17 at 2:30 p.m., CNA-F states the resident was toileted per her routine. This routine included transferring R1 to the commode, giving R1 the hand controller for the lift and the call light. Staff then left the room to give the resident privacy.	21850		

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21850	Continued From page 4 The physician was interviewed on 1/12/17 at 10:05 a.m. and stated R1 had refused further treatment after the fall. Comfort measures were initiated. The resident had a broken femur that occurred during the fall which caused significant swelling and pain in the leg. The resident was put on a morphine pump. R1 died several days later and the death was related to the fall. There was not a facility policy that specified the amount of supervision required related to mechanical lift connection while using the commode. The use of the mechanical lift for transfers or level of supervision while on the commode was not specified in the care plan. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could create interventions to ensure resident's are supervised while still connected to mechanical lifts. Interventions to be sure all receiving devices with wheels are locked or secured to prevent injury. If a variance is indicated, this must be communicated in the resident's care plan and resident has been explained the risks. The administrator and/or designee could provide monitoring for compliance and effectiveness of the policy interventions as necessary in accordance with current standards of practice. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21850		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

May 16, 2017

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

RE: Project Numbers H5240016 and H5240017

Dear Ms. Hoeg:

On March 24, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Office of Health Facility Complaints for an abbreviated standard survey, completed on February 28, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 25, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard, completed on February 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 4, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 28, 2017, effective April 4, 2017 and therefore remedies outlined in our letter to you dated March 24, 2017, 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.

Please contact me if you have questions related to this eNotice.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 16, 2017

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

Re: Enclosed Reinspection Results - Complaint Numbers H5240016 and H5240017

Dear Ms. Hoeg:

On April 25, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on February 28, 2017. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

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cc: Licensing and Certification File