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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Winona Manor	865 Mankato Avenue Winona, MN 55987

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the turning and repositioning care plan requiring assist of two staff for 1 of 3 residents (R1) which resulted in actual harm when R1 fell off the bed sustaining a right tibia and fibula fracture, and a distal end of left femur fracture. The facility had put corrective measures in place on 11/13/25, prior to the start of the survey, therefore, was issued at past non-compliance Findings include: R1's face sheet dated 12/17/25, identified diagnoses of multiple sclerosis (disease that causes numbness, weakness, trouble walking, vision issues, etc.), fracture of upper end of right tibia (fracture just below the knee), fracture of lower end of left femur (lower part of thigh bone), and anxiety. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was able to understand and make self-understood to others, had no cognitive deficits, no behaviors, impairments on both sides of upper and lower extremities, dependent on staff for all activities of daily living (ADL), had a urinary catheter, was incontinent of bowels, and had almost constant mild pain. R1's care plan dated 11/16/22, included interventions informed staff R1 required assist of two with mobility and repositioning. The care plan also directed staff to ensure a pillow is under each leg lengthwise to relieve pressure on heels; use a gentle touch to reposition; prefers to roll on right side; Cross left foot over right to assist and use soaker pad to roll from side to side versus pushing on hips and arms. For toileting, R1 required full assistance, prefer not to use the toilet and alert staff when brief needs changed. The facility reported Nursing Home Incident Report (NHIR) dated 11/13/25, indicated on 11/12/25 at 9:00 p.m., nursing assistant (NA)-A was providing cares to R1 in her room. NA-A rolled R1 onto her side when R1's leg slid over the edge and NA-A repositioned R1's leg. R1's leg started to slip again and due to weight and immobility from multiple sclerosis, R1 slid and rolled out of bed. NA-A caught R1 and attempted to slow down R1's upper portion of body and lay down on the floor protecting R1's head. R1's care plan identified bed mobility and repositioning required assist of two people. R1's care plan on 11/12/25 was revised to include R1 should be a two assist for all peri cares as well as with any turning or positioning that goes along with it due to progression of multiple sclerosis and difficulty supporting herself using the side rail. R1's progress note dated 11/13/25, identified R1 returned to facility around 12:30 a.m., after emergency department visit. Right tibia/fibula fracture and right lower extremity is in a soft cast/ace wrapped. The progress note and/or record did not include details for which R1 was transferred to the hospital. R1's Emergency Department/Urgent Care-Provider note dated 11/13/25, indicated R1 presented to the ED following a fall. X-rays revealed R1 had a right nondisplaced fracture of the proximal tibia and also impacted fracture of the right fibular neck. A splint was placed from proximal thigh down to the foot overlaid with ace wraps. R1 was transferred back to the facility. R1's care plan interventions dated 11/13/25 included assess affected area every shift for skin temperature, peripheral pulses, edema, circulation, motion, sensation. Maintain body in functional alignment and prescribed position: no bending or range of motion/stretches. Monitor color, warmth, movement, sensation, pain, and interventions utilized, ensure soft cast is always in place aside from cleansing of the leg. R1's progress note dated 11/15/25 at 3:30 p.m., identified R1 offered complaints of left leg/knee pain. NA that worked with R1 also indicated during repositioning/cares, the left knee area appeared to become more disfigured and was extremely painful. The area appeared to be edematous just above the knee. R1 was transferred to emergency department. R1's Emergency Department note dated 11/15/25, identified R1 returned to the emergency department for increased left leg pain after fall in the last week that broke right leg. Diagnosis of fracture of distal end of left femur. R1's progress note dated 11/15/25 at 9:33 p.m., identified R1 returned from emergency department with a left distal femur fracture and immobilizer on left leg. R1's Event Report dated 11/18/25, identified R1 fell on [DATE] at 9:30 p.m., R1 was lying in bed on left side facing door while NA-A performed personal cares on the opposite side of the bed. R1's bilateral lower extremities slipped from the bed on the opposite side of NA-A. NA-A reached across the bed and pulled R1's bilateral lower extremities back on the bed. R1's bilateral lower extremities slipped again, and NA-A was unable to pull them back onto the bed. NA-A reached across the bed and held onto R1's torso and slowly lowered R1's upper body to the floor to prevent R1 from hitting head. R1 was laying on her back on the floor at the side of the bed with bilateral lower extremities towards the head of the bed and head and upper body at the foot of the bed. R1 had abnormal alignment and extreme pain with touch to right lower extremity. Immediate intervention was for R1 to be two assist for all peri cares as well as with any turning or positioning that goes along with it due to progression of multiple