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	03/05/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed for 1 of 1 resident (R8) reviewed for self-administration of medication.Findings include:R8's Quarterly Minimum Dat Set (MDS) assessment, dated 2/10/26 indicated R8 was cognitively intact. Further, R8 was independent with eating and basic personal hygiene and dependent on facility staff for mobility and transfers.R8's record lacked an assessment to self-administer medications.During observation and interview on 3/2/26 at 7:01 p.m., a Voltaren Gel (pain relief) tube was observed sitting in a basket on R8's tray table. R8 stated he used the Voltaren Gel on both his knees when he had pain. R8 stated he would use the gel throughout the day and is unsure how many times per day.R8 lacked an order for Voltaren Gel. During observation and interview on 3/4/26 at 8:54 a.m., licensed practical nurse (LPN)-A was observed administering R8's morning medications. The Voltaren Gel remained in the basket on R8's tray table. R8 again stated, he uses the Voltaren Gel on his knees when they are causing him pain. LPN-A completed R8's medication administration and left the room.During an interview on 3/4/26 at 9:01 a.m., LPN-A stated she was unsure if R8 had an order for the Voltaren Gel and if he had been assessed to administer the medication himself. Upon review, LPN-A confirmed R8 had neither an order to use the Voltaren Gel nor an assessment to be able to self-administer the medication. LPN-A stated it is important to have an order for the Voltaren Gel, so the provider team knows all the medications R8 was taking. LPN-A indicated it is important R8 have an assessment to administer his own medication to make sure he is capable to administer the medication and that he can administer the medication as directed by the order.During an interview on 3/4/26 at 11:15 a.m., nurse manager (NM)-A stated medications such as Voltaren Gel should have a provider order. Further, if the resident would like to administer the medication themself, they would need to be assessed to make sure they can administer the medication as directed by the medication order. NM-A stated if a nurse found a medication in a room, she would expect the nurse to follow up to make sure there was an order for the medication, and the resident had been assessed to have the medication in his room. NM-A stated it is important to have an order for all medications and residents are assessed to give the medication, this will ensure the providers are aware of all the medications a resident is taking, and to make sure the resident can safely administer the medication as ordered.During an interview on 3/4/26 at 2:19 p.m., the administrator/director of nursing stated all medications, even pain gels such as Voltaren Gel, need to have a prescriber order to administer. Further, if a resident would like to administer the medication, they would need to be appropriately assessed to ensure the resident can administer the medication as prescribed. The administrator/director of nursing stated if staff found medication in a resident room, she would expect them to verify the medication was ordered and remove the medication if it was not. Additionally, if the medication was ordered she would expect staff to verify if the appropriate self-administration assessment had been completed, removing the medication if it had not.During observation on 3/5/26 at 11:52 a.m., the Voltaren Gel remained sitting in a basket on R8's tray table. Additionally, an order for the Voltaren Gel had not been completed, and assessment for self-administration had not been completed.A facility policy titled Medication Administration dated 12/24, a resident may not be permitted to administer or retain any medication in his/her room unless it is so ordered by the provider and appropriate assessment is completed.

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

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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 0572 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on observation, interview, and record review, the facility failed to ensure the most up to date Nursing Home Resident [NAME] of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 64 residents currently residing in the facility as well as all staff and visitors.Findings include: During observation on 3/3/26, at 11:45 a.m. the Resident [NAME] of Rights poster, dated 1/2019, was observed near the entrance to the building. A second Combined [NAME] of Rights poster, dated 1/2016, was posted next to the elevator going to the second floor.During interview 3/4/26, at 3:29 p.m., administrator stated she was unaware of the newly released Resident [NAME] of Rights poster, effective 1/1/26, which was to replace any previous posters.The facility policy, effective 8/1/21, titled Resident Rights, was reviewed, and identified residents had the right to be informed by the facility of rights granted within the [NAME] of Rights, which was to also include the recourse residents had if rights were violated. The policy identified the [NAME] of Rights were to be posted in a conspicuous location within the facility.

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure facility survey results were posted in an accessible location for residents, staff and visitors. This had the potential to affect all 64 residents residing in the facility as well as staff and visitors.Findings include: On 3/3/26, at 11:45 a.m. a review of the survey results binder located near the elevator was completed. Although the previous recertification survey of 12/5/24 was found within the survey binder, the Life Safety Code (LSC) 2567, completed 12/4/25, was not located in the binder.During interview on 3/3/26, at 1:12 p.m. the administrator stated she was unaware the LSC 2567 survey results were not in the survey binder. Administrator stated it was important for the survey results to be available for review by residents, staff and visitors for so they may be aware of the previous survey results.A request was made for the facility policy for posting of survey results, however, a policy was unavailable.