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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0OUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00302

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245572**

2.STATE VENDOR OR MEDICAID NO.
(L2) **075487000**

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL MANOR NURSING HOME**
(L4) **403 COLONIAL AVENUE**
(L5) **LAKEFIELD, MN** (L6) **56150**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 07/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/04/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/20/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245572
August 4, 2015

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

Dear Ms. Goette:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 23, 2015 the above facility is certified for or recommended for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 4, 2015

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

RE: Project Number S5572025

Dear Ms. Goette:

On June 16, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 4, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 4, 2015, effective June 23, 2015 and therefore remedies outlined in our letter to you dated June 16, 2015, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	7/20/2015

Name of Facility	Street Address, City, State, Zip Code
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**06/09/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**06/09/2015**	ID Prefix **F0467** Reg. # **483.70(h)(2)** LSC	**06/04/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	SR/KJ	08/04/2015	16022	07/20/2015
Reviewed By CMS RO				

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/4/2015				

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing **01 - MAIN BUILDING 01**	7/10/2015

Name of Facility	Street Address, City, State, Zip Code
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **06/08/2015**	ID Prefix	Correction Completed **06/23/2015**	ID Prefix	Correction Completed **06/04/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0052		LSC K0056		LSC K0154	
ID Prefix	Correction Completed **06/04/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0155		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	08/04/2015	35482	07/10/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/2/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 0OUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00302

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245572**

2.STATE VENDOR OR MEDICAID NO.
(L2) **075487000**

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL MANOR NURSING HOME**
(L4) **403 COLONIAL AVENUE**
(L5) **LAKEFIELD, MN** (L6) **56150**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/04/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Heim, HPR - Social Work Specialist 07/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/17/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 16, 2015

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

RE: Project Number S5572025

Dear Ms. Goette:

On June 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 4, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan for 1 of 3 residents (R7) identified as incontinent of urine. Findings include: R7's care plan, reviewed by the facility on 5/11/15, revealed R7 was frequently incontinent of urine. The care plan directed two staff to use a Hoyer lift, with toileting the resident, at least every two hours and when necessary (prn) during waking hours.	F 282	Staff education took place 06/03/2015-06/09/2015 regarding following resident care plans and communicating observed changes to the charge nurse. R7's care plan was reviewed and revised on 06/04/2015 to reflect toileting needs. Other residents that potentially may be affected will be identified by completion of Bowel & Bladder Assessments and communication by staff of resident changes related to toileting needs.	6/9/15

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

Electronically Signed | 06/29/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

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F 282	Continued From page 1 On 6/02/15, from 8:10 a.m. to 9:44 a.m. R7 was continuously observed. At 9:44 a.m. R7 was taken to her room and transferred with a Hoyer lift and assistance of nursing assistants (NA-A) and NA-B, from the wheelchair to the bed. Once in bed, R7's incontinent product was checked and noted to be wet per interview with nursing assistant (NA-A.) Peri care was provided to R7 and the incontinent product changed. However, R7 had not been offered the opportunity to use the toilet or commode prior to being transferred into bed. NA-A stated R7 could use the commode, but the bathroom was not used, as it was too hard to get the transfer equipment into the bathroom. On 6/03/15, at 7:24 a.m. R7 was observed to be transferred from the wheelchair into bed with the use of a Hoyer lift and assistance from NA-A and NA-C. R7 was noted to be dry and this was confirmed by NA-C. R7 had not been provided the opportunity to use the toilet or commode as required by the care plan. NA-C was interviewed and stated staff could have assisted R7 to use the commode for voiding. At present. R7 staff provided R7 a check and change of the incontinent brief. NA-C agreed the bathroom was too small and did not allow one to use the Hoyer lift to toilet the resident. On 6/03/15, at 7:35 a.m. the director of nurses (DON) reviewed the care plan with the surveyor. The section of the care plan which addressed the use of briefs and the requirement of two assist and Hoyer lift for toileting needs was discussed with the DON. The DON stated "toileting" meant the use of either the toilet or commode. The DON	F 282	Any changes to a residents' toileting program will be placed on the CNA Care Record to indicate new or updated toileting plans. Random audits will be completed by DON/designee comparing toileting plan to resident care plan to ensure that the care plan reflects resident needs and desires as appropriate and that staff are following the care plan. Audits will be discussed at internal quality assurance meetings.	

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F 282	Continued From page 2 stated the last she knew R7 was able to verbalize when she needed to void. On 6/3/15 at 1:00 p.m. when the DON was informed staff were not consistently toileting or encouraging R7 to use the commode, the DON stated she would follow up to determine the resident's current status. At 2:00 p.m. the DON stated R7 had used the commode in the morning and at times refused to use the commode. R7 preferred to use the commode for bowel movements, but would still decline to use it at times. The DON verified the care plan did not reflect R7's occasional refusals to use the commode.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the appropriate services to minimize urinary incontinent episodes for 1 of 3 residents (R7) identified as frequently incontinent or urine.	F 315	Re-education provided to nursing staff 06/03/2015-06/09/2015 regarding toileting residents per plan of care and communicating changes in toileting needs as they occur.	6/9/15

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F 315	Continued From page 3 Findings include: R7 was admitted to the facility on 1/23/15. An initial minimum data set (MDS) completed on 1/30/15, indicated R7 was occasionally incontinent of urine and by the time of a quarterly MDS dated 4/30/15, R7's urinary status had changed to frequently incontinent of urine. A Bladder Assessment form dated 1/29/15, revealed R7 was occasionally incontinent of urine and had a voiding pattern of every 2-6 hours during waking hours and 0-2 times at night. The assessment indicated the family reported R7 had bladder problems for years with frequency, urgency and incontinence. To help with R7's incontinence a neurostimulator had been placed in 2005 and the batteries were changed in 2010. A bladder reassessments completed on 4/30/15, revealed R7 was now frequently incontinent of urine, was on a toileting program, required extensive assist of two staff with toileting needs and did not always accurately report the need to void. R7's care plan, reviewed by the facility on 5/11/15, revealed R7 was frequently incontinent of urine. The care plan directed two staff to use a Hoyer lift, with toileting the resident, at least every two hours and when necessary (prn) during waking hours. On 6/02/15, from 8:10 a.m. to 9:44 a.m. R7 was continuously observed. At 9:44 a.m. R7 was taken to her room and transferred with a Hoyer lift and assistance of nursing assistants (NA-A) and NA-B, from the wheelchair to the bed. Once in bed, R7's incontinent product was checked and noted to be wet per interview with nursing	F 315	Residents that have the potential to be affected will be identified through bladder assessments and communication by staff of changes in toileting needs. To prevent recurrence, new toileting programs or changes to current toileting programs will be placed on CNA Care Records to indicate new or updated plans. To monitor performance, DON/designee will complete random audits to ensure that staff are following resident care plans and toileting plans as outlined in CNA Care Records. Audits will be discussed at internal quality assurance meetings.	

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F 315	Continued From page 4 assistant (NA-A.) Peri care was provided to R7 and the incontinent product changed. However, R7 had not been offered the opportunity to use the toilet or commode prior to being transferred into bed. NA-A stated R7 could use the commode, but the bathroom was not used, as it was too hard to get the transfer equipment into the bathroom. On 6/03/15, at 7:24 a.m. R7 was observed to be transferred from the wheelchair into bed with the use of a Hoyer lift and assistance from NA-A and NA-C. R7 was noted to be dry and this was confirmed by NA-C. R7 had not been provided the opportunity to use the toilet or commode as required by the care plan. NA-C was interviewed and stated staff could have assisted R7 to use the commode for voiding. At present staff provided R7 a check and change of the incontinent brief. NA-C agreed the bathroom was too small and did not allow one to use the Hoyer lift to toilet the resident. On 6/3/15 at 1:00 p.m. when the DON was informed staff were not consistently toileting or encouraging R7 to use the commode, the DON stated she would follow up to determine the resident's current status. At 2:00 p.m. the DON stated the facility did not know if the neurostimulator was still working as the family had decided to no longer actively pursue the use. The DON stated a minimally invasive incision would be required to determine if the neurostimulator was still working and the family had chosen not to pursue that option. The DON stated R7 would refuse to use the commode at times and R7 preferred to use the commode for bowels movements, but would still decline to use	F 315		

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F 315	Continued From page 5 the commode for bowel movements at times. When the DON was informed that neither the most recent bladder assessment dated 4/30/15 or the care plan dated, as having been reviewed by staff on 5/11/15, reflected R7's occasional refusals to use the commode, the DON had no comment.	F 315		
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the exhaust vent system in all resident bathrooms which contributed to a concern about air circulation in the room for 1 of 29 residents reviewed, (R11). Findings include: On 6/3/15 at 11:58 a.m. R11 reported her room felt stuffy and there was only air circulation when the door was open. Surveyor noted the room felt stuffy. No other residents interviewed expressed concern about a stuffy room or air circulation. On 6/3/15 at 12:15 p.m. the director of environmental services [DES] was observed checking the exhaust vents in bathrooms by placing a piece of toilet paper up to the exhaust. The exhaust did not produce any air suction for the toilet paper to cling to the exhaust vent for rooms tested on the west unit: W10, W3, W11,	F 467	Corrective action was completed on 06/03/2015 for resident affected by replacing exhaust fan motor on roof. Other residents that potentially may be affected will be identified through weekly exhaust fan testing. The Director of Environmental Services will test exhaust fan functioning weekly in random resident bathrooms by placing a piece of toilet paper up to the exhaust vent to check for air suction and documenting the date, room tested and function capability. This plan of correction will be monitored by the Administrator randomly for completion of test and results of testing will be reviewed with monthly Safety Meeting.	6/4/15

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F 467	Continued From page 6 W8, W12, W13, W7, W5, W4 and W1. On the northwest unit bathrooms in rooms NW1, NW8, NW9 and NW16 were tested with similar results. DES explained that each unit, northwest and west, ran on the same system so the exhaust vents for all resident bathrooms were not functioning. DES reported no one had expressed concerns related to hot or stuffy rooms to him and it was not documented on his maintenance work log. DES reported he did not do routine inspections of the exhaust vent fans. On 6/3/15 at 12:20 p.m. the administrator reported the director of environmental services should have completed routine inspections of the exhaust vents. The administrator reported there was no policy related to exhaust vents or maintenance work log. The Maintenance Work Log for 4/13/15 through 6/3/15 was reviewed. No concern addressed stuffy rooms. No routine maintenance of exhaust vents was documented.	F 467		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 2, 2015. At the time of this survey, Colonial Manor Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Colonial Manor Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1979, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1999, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a	K 000		

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K 000	Continued From page 2 capacity of 37 beds and had a census of 29 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the proper interval for the required annual inspection and testing of the building fire alarm system had not been maintained, in accordance with the requirements NFPA 72 (1999 edition). In a fire emergency, this deficient practice could adversely affect 37 of 37 residents, staff and visitors. FINDINGS INCLUDE: On 06/02/2015 at 10:00 AM, during a review of available records, it was confirmed the required annual inspection/testing of the building fire alarm system was conducted by a contract vendor on	K 052	Director of Environmental Services contacted Fire Alarm System company for annual testing and review of system. Fire Alarm System was reviewed and tested on 06/08/2015. Director of Environmental Services is responsible for ensuring annual fire alarm system is reviewed and to arrange review date prior to needed review in the future.	6/8/15

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K 052	Continued From page 3 05/08/2014, and had not yet been condcuted at the time of inspection. As such, more than 12 months had elapsed between annual tests. This deficient practice was not in conformance with the requirements at NFPA 72 (99) Chapter 7, Section 7-3.2. This finding was confirmed with the facility's chief building engineer (DL).	K 052		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. FINDINGS INCLUDE: On facility tour between 9:30 AM and 12:00 PM on 06/02/2015, observation revealed that:	K 056	Sprinkler Company was contacted on 06/03/2015 regarding recent inspection and need for two additional sprinkler heads. Representative from company inspected areas and sprinkler heads were ordered 06/17/2015 for the walk-in freezer and water storage room. Installation of sprinkler heads completed 06/23/2015. Director of Environmental Services is	6/23/15

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K 056	Continued From page 4 #1: The Kitchen Walk-in Freezer does not have a fire sprinkler protection. #2: The water jug storage room in the hallway to the Kitchen does not have fire sprinkler protection. This deficient practice was confirmed by the Facility Maintenance Director (DL) at the time of discovery.	K 056	responsible for monitoring sprinkler system.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 12:30 PM on 06/02/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire	K 154	A sprinkler system procedure plan was developed by the Administrator and Director of Environmental Services for when the fire sprinkler system is out of service for more than 4 hours. This plan has been signed by the administrator and will be reviewed annually by the administrator.	6/4/15

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K 154	Continued From page 5 sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (DL) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 12:30 PM on 06/02/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (DL) at the time of discovery.	K 155	A fire watch procedure plan was developed for when the fire alarm system is out of service for more than 4 hours by the Administrator and the Director of Environmental Services. This plan has been signed by the Administrator and will be reviewed annually by the Administrator of the facility.	6/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR NURSING HOME	**403 COLONIAL AVENUE** **LAKEFIELD, MN 56150**

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
June 16, 2015

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5572025

Dear Ms. Goette:

The above facility was surveyed on June 1, 2015 through June 4, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 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 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 after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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 me.

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 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.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00302	A. BUILDING: _____ B. WING _____	06/04/2015

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

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2 000	Continued From page 1 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. On 6/1/2015 through 6/4/2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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 surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care	2 565	Corrected	6/9/15

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2 565	Continued From page 2 plan for 1 of 3 residents (R7) identified as incontinent of urine. Findings include: R7's care plan, reviewed by the facility on 5/11/15, revealed R7 was frequently incontinent of urine. The care plan directed two staff to use a Hoyer lift, with toileting the resident, at least every two hours and when necessary (prn) during waking hours. On 6/02/15, from 8:10 a.m. to 9:44 a.m. R7 was continuously observed. At 9:44 a.m. R7 was taken to her room and transferred with a Hoyer lift and assistance of nursing assistants (NA-A) and NA-B, from the wheelchair to the bed. Once in bed, R7's incontinent product was checked and noted to be wet per interview with nursing assistant (NA-A.) Peri care was provided to R7 and the incontinent product changed. However, R7 had not been offered the opportunity to use the toilet or commode prior to being transferred into bed. NA-A stated R7 could use the commode, but the bathroom was not used, as it was too hard to get the transfer equipment into the bathroom. On 6/03/15, at 7:24 a.m. R7 was observed to be transferred from the wheelchair into bed with the use of a Hoyer lift and assistance from NA-A and NA-C. R7 was noted to be dry and this was confirmed by NA-C. R7 had not been provided the opportunity to use the toilet or commode as required by the care plan. NA-C was interviewed and stated staff could have assisted R7 to use the commode for voiding. At present. R7 staff provided R7 a check and change of the incontinent brief. NA-C agreed the bathroom was	2 565		

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2 565	Continued From page 3 too small and did not allow one to use the Hoyer lift to toilet the resident. On 6/03/15, at 7:35 a.m. the director of nurses (DON) reviewed the care plan with the surveyor. The section of the care plan which addressed the use of briefs and the requirement of two assist and Hoyer lift for toileting needs was discussed with the DON. The DON stated "toileting" meant the use of either the toilet or commode. The DON stated the last she knew R7 was able to verbalize when she needed to void. On 6/3/15 at 1:00 p.m. when the DON was informed staff were not consistently toileting or encouraging R7 to use the commode, the DON stated she would follow up to determine the resident's current status. At 2:00 p.m. the DON stated R7 had used the commode in the morning and at times refused to use the commode. R7 preferred to use the commode for bowel movements, but would still decline to use it at times. The DON verified the care plan did not reflect R7's occasional refusals to use the commode. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 565		

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2 910	Continued From page 4	2 910		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan for 1 of 3 residents (R7) identified as incontinent of urine. Findings include: R7's care plan, reviewed by the facility on 5/11/15, revealed R7 was frequently incontinent of urine. The care plan directed two staff to use a Hoyer lift, with toileting the resident, at least every two hours and when necessary (prn) during waking hours. On 6/02/15, from 8:10 a.m. to 9:44 a.m. R7 was continuously observed. At 9:44 a.m. R7 was	2 910	Corrected	6/9/15

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2 910	Continued From page 5 taken to her room and transferred with a Hoyer lift and assistance of nursing assistants (NA-A) and NA-B, from the wheelchair to the bed. Once in bed, R7's incontinent product was checked and noted to be wet per interview with nursing assistant (NA-A.) Peri care was provided to R7 and the incontinent product changed. However, R7 had not been offered the opportunity to use the toilet or commode prior to being transferred into bed. NA-A stated R7 could use the commode, but the bathroom was not used, as it was too hard to get the transfer equipment into the bathroom. On 6/03/15, at 7:24 a.m. R7 was observed to be transferred from the wheelchair into bed with the use of a Hoyer lift and assistance from NA-A and NA-C. R7 was noted to be dry and this was confirmed by NA-C. R7 had not been provided the opportunity to use the toilet or commode as required by the care plan. NA-C was interviewed and stated staff could have assisted R7 to use the commode for voiding. At present. R7 staff provided R7 a check and change of the incontinent brief. NA-C agreed the bathroom was too small and did not allow one to use the Hoyer lift to toilet the resident. On 6/03/15, at 7:35 a.m. the director of nurses (DON) reviewed the care plan with the surveyor. The section of the care plan which addressed the use of briefs and the requirement of two assist and Hoyer lift for toileting needs was discussed with the DON. The DON stated "toileting" meant the use of either the toilet or commode. The DON stated the last she knew R7 was able to verbalize when she needed to void. On 6/3/15 at 1:00 p.m. when the DON was	2 910		

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2 910	Continued From page 6 informed staff were not consistently toileting or encouraging R7 to use the commode, the DON stated she would follow up to determine the resident's current status. At 2:00 p.m. the DON stated R7 had used the commode in the morning and at times refused to use the commode. R7 preferred to use the commode for bowel movements, but would still decline to use it at times. The DON verified the care plan did not reflect R7's occasional refusals to use the commode. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise procedures related to ensuring residents maintain the highest practicable level of bladder continence. The DON or designee could train all staff on these procedures and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of	21426		6/17/15

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21426	Continued From page 7 Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow policy and procedures pertaining to the correct way to document the results of tuberculosis testing for 2 of 6 residents (R7, R8) admitted to the facility since 1/15; and for 1 of 6 employees (RN-B) hired since 12/3/14. Findings include: R7 was admitted to the facility on 1/23/15. A first step tuberculin skin test was completed and recorded on the Tuberculin skin testing (TST) form as 0 millimeters (mm) and negative on 1/26/15. However, the second step tuberculin test was read on 2/8/15, as negative, but the millimeters were not recorded. On 6/2/15, at 3:23 p.m. registered nurse (RN-A) verified the TST documentation for the second step TST test for R7 did not include documentation of the millimeters of induration. R8 was admitted to the facility on 1/16/15. A first step tuberculin skin test was completed and recorded on the TST form as negative on 1/18/15, and the second step was documented as negative on 2/2/15. However, documentation of	21426	Corrected	

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21426	Continued From page 8 the millimeters was not recorded for either skin test. On 6/2/15, at 3:00 p.m. RN-A reviewed R8's TST form and medication administration records from 1/15 and 2/15. RN-A verified the millimeters of induration had not been recorded when the TST ' s were read. RN-B was hired by the facility on 12/15/14. A review of RN-B's personnel record revealed the first step of a TST was administered on 12/12/14, and recorded as 0 mm and negative on 12/15/14. The second TST was administered on 1/26/15, and read as negative on 1/28/15, but the millimeters of induration were not recorded. On 6/3/15, at 1:00 p.m. RN-A had no comment when shown the millimeters of induration had not been documented for RN-B's second TST results. The facility's policy titled Infection Control-Resident Mantoux dated as reviewed and revised 1/15 indicated "Correct documentation of the mantoux results include the measurement in "millimeters" not just circling of positive or negative." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise procedures related to tuberculosis screening. The DON or designee could train all licensed nurses on these procedures and monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		

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23240	Continued From page 9	23240		
23240	MN Rule 4658.5405 Ventilation Requirements; Existing Constructn Existing facilities must have mechanical exhaust ventilation in the kitchen, laundry, soiled linen collection room, soiled utility rooms, and toilet areas, except if the toilet area is private or semiprivate, and is provided with window ventilation. Ventilation must be provided according to part 4658.4520. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the exhaust vent system in all resident bathrooms which contributed to a concern about air circulation in the room for 1 of 29 residents reviewed, (R11). Findings include: On 6/3/15 at 11:58 a.m. R11 reported her room felt stuffy and there was only air circulation when the door was open. Surveyor noted the room felt stuffy. No other residents interviewed expressed concern about a stuffy room or air circulation. On 6/3/15 at 12:15 p.m. the director of environmental services [DES] was observed checking the exhaust vents in bathrooms by placing a piece of toilet paper up to the exhaust. The exhaust did not produce any air suction for the toilet paper to cling to the exhaust vent for rooms tested on the west unit: W10, W3, W11, W8, W12, W13, W7, W5, W4 and W1. On the northwest unit bathrooms in rooms NW1, NW8, NW9 and NW16 were tested with similar results. DES explained that each unit, northwest and	23240	Corrected	6/4/15

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COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

(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
23240	Continued From page 10 west, ran on the same system so the exhaust vents for all resident bathrooms were not functioning. DES reported no one had expressed concerns related to hot or stuffy rooms to him and it was not documented on his maintenance work log. DES reported he did not do routine inspections of the exhaust vent fans. On 6/3/15 at 12:20 p.m. the administrator reported the director of environmental services should have completed routine inspections of the exhaust vents. The administrator reported there was no policy related to exhaust vents or maintenance work log. The Maintenance Work Log for 4/13/15 through 6/3/15 was reviewed. No concern addressed stuffy rooms. No routine maintenance of exhaust vents was documented. SUGGESTED METHOD OF CORRECTION: The director of environmental services (DES) could review and revise procedures related to regular maintenance and monitoring of the exhaust ventilation system. The DES could train all staff on these procedures and how to report concerns. The DES could monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	23240		