DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1RJI

	PAKI I -	TO BE COMPI	LETED BY	THE STAT	E SURVEY AGENCY		Facility ID: 00982
MEDICARE/MEDICAID PROVID NO.(L1) 245552	DER	3. NAME AND AI (L3) COLONIAI	MANOR OF	BALATON	N	4. TYPE OF ACT	ION: 7 (L8) 2. Recertification
2. STATE VENDOR OR MEDICALE	NO.	(L4) HIGHWAY	14 EAST PO	BOX 219		3. Termination	4. CHOW
(L2) 570014100		(L5) BALATON,	MN		(L6) 56115	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATE	GORY	<u>02</u> (L7)		
(L9) 07/01/2015		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Aft	ter Compiaint
6. DATE OF SURVEY 12/	19/2016 (L34	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	DING DATE: (L35)
8. ACCREDITATION STATUS:)(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		12/31) (L33)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY		AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of	٠.	
To (b):		_	equirements e Based On:		2. Technical Personne 3. 24 Hour RN	6. Scope of 3 7. Medical I	
		1. A	cceptable POC		4. 7-Day RN (Rural SI	·	
12.Total Facility Beds	33 (L18)				5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	33 (L17)	X B. Not in Con Requirements	npliance with Pro and/or Applied	-	* Code: A *	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN	•			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
33							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Joseph Garvey, H	FE NE II		02/01/2017	(L19)	a <u>mala Fiske-Downing,</u>	Enforcement Sp	pecialist2/2/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA R	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBII	LITY		MPLIANCE WIT	TH CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	uncial Solvency (HCFA-2: rol Interest Disclosure Stn	
1. Facility is Eligible to I	Participate	KiGi	moner.		3. Both of the Abov		in (110171 1313)
2. Facility is not Eligible	(L21)						
	(E21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	B DATE	ENDING DA	ATE	VOLUNTARY 0	<u>INVOLU</u>	UNTARY
04/01/1991					01-Merger, Closure	05-Fail to	o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-11001	ider Status Change
(L27)	D D . 10		(L44)			00-Activ	/e
(=-/)	B. Rescind Si	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		06201					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVA	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245552

February 1, 2017

Mr. Charles Ness, Administrator Colonial Manor Of Balaton Highway 14 East PO Box 219 Balaton, MN 56115

Dear Mr. Ness:

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 December 25, 2017 the above facility is certified for:

33 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 33 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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER A. Building	
245552 _{Y1} B. Wing _{Y2} 12/20/20)16 _{Y3}
NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE	
COLONIAL MANOR OF BALATON HIGHWAY 14 EAST PO BOX 219	
BALATON, MN 56115	

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).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix		C	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.15(a)	С	ompleted	Reg. #	483.15	(c)(6)	Completed	Reg. #	483.20(g) - (j)		Completed
LSC		12	2/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	F0279	C	Correction	ID Prefix	F0282		Correction	ID Prefix	F0312		Correction
Reg. #	483.20(d), 483.2	^{20(k)(1)} C	ompleted	Reg. #	483.20	(k)(3)(ii)	Completed	Reg. #	483.25(a)(3)		Completed
LSC		12	2/13/2016	LSC			- 12/13/2016 -	LSC			12/13/2016
ID Prefix	F0315	C	Correction	ID Prefix	F0323		Correction	ID Prefix	F0353		Correction
Reg. #	483.25(d)	С	ompleted	Reg. #	483.25	(h)	Completed	Reg. #	483.30(a)		Completed
LSC		12	2/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	F0356	C	Correction	ID Prefix	F0412		Correction	ID Prefix	F0441		Correction
Reg. #	483.30(e)	С	ompleted	Reg. #	483.55	(b)	Completed	Reg. #	483.65		Completed
LSC		12	2/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix		C	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.75(o)(1)	C	ompleted	Reg. #			Completed	Reg. #			Completed
LSC		12	2/13/2016	LSC			-	LSC			
REVIEWI STATE A		REVIEWED (INITIALS)	ВY KS/kfd	DATE 1/24/20	17	SIGNATURE OF	SURVEYOR	34083		DATE 12/20	0/2016
REVIEWI CMS RO	ED BY	REVIEWED (INITIALS)) BY	DATE		TITLE				DATE	
FOLLOW 11/3/201	UP TO SURVE	Y COMPLET	ED ON			R ANY UNCORRECTED DEFICIENCE					s 🗆 NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A Building 01 - MAIN BUILDING 01	LE CONSTRUCTION ng 01 - MAIN BUILDING 01		DATE OF REV	'ISIT
	B. Wing	,	Y2	12/29/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
COLONIAL MANOR OF BALAT	ON	HIGHWAY 14 EAST PO BOX 219			
		BALATON, MN 56115			

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).

ITE Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	IFPA 101		Completed	Reg. #	NFPA 101		Completed
LSC	K0133	12/25/2016	LSC K	(0321		12/25/2016	LSC	K0345		11/02/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	IFPA 101		Completed	Reg. #	NFPA 101		Completed
LSC	K0346	12/09/2016	LSC K	(0354		12/09/2016	LSC	K0372		12/25/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	IFPA 101		Completed	Reg. #	NFPA 101		Completed
LSC	K0712	11/02/2016	LSC K	(0741		11/30/2016	LSC	K0781		11/30/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #			Completed	Reg. #			Completed
LSC	K0918	11/02/2016	LSC _				LSC			
ID Prefix		Correction	ID Prefix _			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC _				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) KS/kfd	DATE 2/1/2017		NATURE OF	SURVEYOR	3548	2	DATE 12/2	29/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	ТІТ	LE				DATE	
FOLLOW 11/2/201		Y COMPLETED ON				CTED DEFICIEN ES (CMS-2567)		S A SUMMARY OF HE FACILITY?		s 🗆 no



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

February 1, 2017

Mr. Charles Ness, Administrator Colonial Manor Of Balaton Highway 14 East PO Box 219 Balaton, MN 56115

Re: Reinspection Results - Project Number S5552028

Dear Mr. Ness:

On December 20, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 20, 2016, that included an investigation of complaint number H5552012. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVI	SIT		
IDENTIFICATION NUMBER	A. Building						
00982 _{Y1}	B. Wing	Y	2	12/20/2016	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
COLONIAL MANOR OF BALAT	ON	HIGHWAY 14 EAST PO BOX 219					
		BALATON, MN 56115					
This report is completed by a S	tate surveyor to show those deficiencies p	reviously reported that have been corrected ar	nd t	he date such			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	EM		DATE	ITEM	1		DATE	ITEM			DATE
Y4	ļ		Y5	Y4			Y5	Y4			Y5
ID Prefix	20565		Correction	ID Prefix	20800		Correction	ID Prefix	20830		Correction
Reg. #	MN Rule 4658.0 Subp. 3	0405	Completed	Reg. #	MN Ru Subp.	le 4658.0510 1	Completed	Reg. #	MN Rule 4658.05 Subp. 1	520	Completed
LSC			12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	20850		Correction	ID Prefix	20860		Correction	ID Prefix	20910		Correction
Reg. #	MN Rule 4658.0 Subp. 2 D	0520	Completed	Reg. #	MN Ru Subp. 2	le 4658.0520 2 F.	Completed	Reg. #	MN Rule 4658.05 Subp. 5 A.B	525	Completed
LSC			12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	21805		Correction	ID Prefix	21870		Correction	ID Prefix			Correction
Reg. #	MN St. Statute Subd. 5	144.651	Completed	Reg. #	MN St. Subd.	Statute 144.651	Completed	Reg. #			Completed
LSC			12/13/2016	LSC			12/13/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			-
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			_	LSC			
DEVIEW	ED DV	DEV/JEW	(ED DV	DATE		OLOMATURE OF	CHRYEVOR			I	
STATE A		REVIEW (INITIAL KS		DATE 2/1/201	7_	SIGNATURE OF	SUKVEYUK	3408	3	DATE 12/	20/2017
REVIEW CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOV 11/3/201	VUP TO SURVE	Y COMPL	ETED ON			R ANY UNCORRE CTED DEFICIENC				YE	s 🔲 no

Page 1 of 1 EVENT ID: 1RJI12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEI PART I - TO BE C

DICAID CERTIFICATION AND TRANSMITTAL	ID: 1RJI
COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00982
AND ADDRESS OF FACILITY	4 TYPE OF ACTION: 2(18)

MEDICARE/MEDICAID PROV NO.(L1)		3. NAME AND ADDRESS OF FACILITY (L3) COLONIAL MANOR OF BALATON (L4) HIGHWAY 14 EAST PO BOX 219 (L5) BALATON, MN				56115	4. TYPE OF AC 1. Initial 3. Termination 5. Validation 7. On-Site Visit	FION: 2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE O	F OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7		8. Full Survey A	fter Complaint
(L9) 07/01/2015 6. DATE OF SURVEY 11 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 03/2016 L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 14 CORF 15 ASC 16 HOSPICE	22 CLIA	FISCAL YEAR EN	
11LTC PERIOD OF CERTIFICATI		10.THE FACILITY	' IS CERTIFIED	AS:				
From (a): To (b):		A. In Complia Program Re Compliance			2. Tec	chnical Personnel	7. Medical	f Services Limit Director
12.Total Facility Beds 13.Total Certified Beds	33 (L18) 33 (L17)	X B. Not in Con Requirements	apliance with Prog		5. Life * Code:	e Safety Code B *	9. Beds/Ro (L12)	om
14. LTC CERTIFIED BED BREAKI	OOWN		**		15. FACILITY			
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) o	or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE 17. SURVEYOR SIGNATURE	MARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):	18. STATE SU	RVEY AGENCY	APPROVAL	Date:
Joseph Garvey,	HFE NE II	1	2/05/2016	(L19) Ka	a <u>mala Fisk</u>	e-Downing, I	Enforcement S	pecialist12/30/2016 (L20)
	HFE NE II ART II - TO BE			(L19)				(L20)
	ART II - TO BE (BILITY o Participate	COMPLETED I		CGIONAL	21. 1. 2.	R SINGLE S	TATE AGENCY ncial Solvency (HCFA- nl Interest Disclosure Solvency	(L20) 2572)
19. DETERMINATION OF ELIGIE 1. Facility is Eligible to	ART II - TO BE (BILITY o Participate ble	COMPLETED I 20. COM RIGH	BY HCFA RE	CGIONAL H CIVIL	21. 1. 2. 3.	R SINGLE S' Statement of Finan Ownership/Contro	TATE AGENCY ncial Solvency (HCFA- ol Interest Disclosure Si ::	(L20) 2572)
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P. 19. DETERMINATION OF ELIGIE 1. Facility is Eligible to 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/01/1991 (L24) 25. LTC EXTENSION DATE:	ART II - TO BE (BILITY o Participate ble (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI	20. COMPLETED I 20. COM RIGH MENT 24 G DATE	BY HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM	CGIONAL H CIVIL	21. 1. 2. 3. 26. TERMIN. VOLUNTARY 01-Merger, Clc 02-Dissatisfact 03-Risk of Invo	R SINGLE S'. Statement of Finan Ownership/Contro Both of the Above ATION ACTION:	TATE AGENCY Incial Solvency (HCFA- ol Interest Disclosure Solvency INVOI 05-Fail ement 06-Fail 0THE	(L30) (L30) UNTARY to Meet Health/Safety to Meet Agreement R vider Status Change
P. 19. DETERMINATION OF ELIGIBE 1. Facility is Eligible to 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/01/1991 (L24)	ART II - TO BE (BILITY o Participate ble (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspension	20. COMPLETED I 20. CO	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAT (L25)	CGIONAL H CIVIL	21. 1. 2. 3. 26. TERMIN. VOLUNTARY 01-Merger, Clc 02-Dissatisfact 03-Risk of Invo	R SINGLE S' Statement of Finan Ownership/Contro Both of the Above ATION ACTION: 00 sure ion W/ Reimburse luntary Termination	TATE AGENCY Incial Solvency (HCFA- ol Interest Disclosure Solvency INVOI 05-Fail ement 06-Fail 07-Pro	(L30) (L30) UNTARY to Meet Health/Safety to Meet Agreement R vider Status Change
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P. 19. DETERMINATION OF ELIGIE 1. Facility is Eligible to 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/01/1991 (L24) 25. LTC EXTENSION DATE: (L27)	ART II - TO BE (BILITY o Participate ble (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind St	20. COMPLETED I 20. CO	BY HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAT (L25) (L44) (L45)	CGIONAL H CIVIL	21. 1. 2. 3. 26. TERMIN. VOLUNTARY 01-Merger, Clc 02-Dissatisfact 03-Risk of Invo 04-Other Reaso	R SINGLE S'. Statement of Finan Ownership/Contro Both of the Above ATION ACTION: 00 00 00 00 00 00 00 00 00	TATE AGENCY Incial Solvency (HCFA- ol Interest Disclosure Solvency INVOI 05-Fail ement 06-Fail 07-Pro	(L30) (L30) UNTARY to Meet Health/Safety to Meet Agreement R vider Status Change
P. 19. DETERMINATION OF ELIGIE 1. Facility is Eligible to 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 04/01/1991 (L24) 25. LTC EXTENSION DATE: (L27)	ART II - TO BE (BILITY o Participate ble (L21) 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATT A. Suspension B. Rescind St	20. COMPLETED I 20. COMPLETED I 20. COMPLETED I 20. COMPLETED I 20. TOMPLETED I 21. COMPLETED I 22. COMPLETED I 23. COMPLETED I 24. COMPLETED I 25. COMPLETED I 26. COMPLETED I 26. COMPLETED I 27. COMPLETED I 28. COMPLETED I 29. COMPLETED I 20. CO	3Y HCFA RE IPLIANCE WITH HTS ACT: 4. LTC AGREEM ENDING DAI (L25) (L44) (L45) (CARRIER NO.	CGIONAL H CIVIL MENT TE (L31)	21. 1. 2. 3. 26. TERMIN. VOLUNTARY 01-Merger, Clc 02-Dissatisfact 03-Risk of Invo 04-Other Reaso	R SINGLE S'. Statement of Finan Ownership/Contro Both of the Above ATION ACTION: 00 00 00 00 00 00 00 00 00	TATE AGENCY Incial Solvency (HCFA- ol Interest Disclosure Solvency INVOI 05-Fail ement 06-Fail 07-Pro	(L30) (L30) UNTARY to Meet Health/Safety to Meet Agreement R vider Status Change



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 18, 2016

Mr. Charles Ness, Administrator Colonial Manor Of Balaton Highway 14 East PO Box 219 Balaton, Minnesota 56115

RE: Project Number S5552028 and H5552012

Dear Mr. Ness:

On November 3, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H55552012. The investigation found the complaint substantiated at F241, F244, F312, F315 and F353.

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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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:

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: kathryn.serie@state.mn.us

Phone: (507) 476-4233 Fax: (507) 344-2723

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 December 13, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 13, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 February 3, 2017 (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 May 3, 2017 (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 electronic 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:

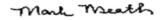
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 11/30/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY IPLETED
		245552	B. WING	i			C 03/2016
	PROVIDER OR SUPPLIER	TON		HIG	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 14 EAST PO BOX 219 ALATON, MN 56115	11/	00/2010
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F 000	INITIAL COMMENT	rs	F 0	000			
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					
		vey was conducted and tion were also completed at dard survey.					
F 241 SS=D	completed. The cor and deficiencies we F312, F315 and F3	complaint # H5552012 was mplaints were substantiated ere cited at F241, F244, F282, 53. AND RESPECT OF	F 2	241			12/13/16
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in s or her individuality.					
I ABORATOR\	by: Based on observation review the facility facall light requests a manner for 3 of 3 research.	NT is not met as evidenced ion, interview and document tiled to promptly respond to nd/or speak in a respectful esidents (R6, R31, R29) who	NATURE		1. Corrective action as it applies to R29, R6. DON B.R. discussed with resident their concern with call light responses. Informed them of staff	each	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

11/30/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 241	Findings include: R6's annual Minima assessment dated extensive assist of transfers. R6's annidentified a Brief Int (BIMS) score of 12 impairment. The M delusions or psychominimum indicators. During observation at 6:30 p.m. R6 was light on. R6 was obwheelchair beside Interest of the second and the second and the second and the second and did not set though his call light 6:51 p.m. NA-B was room without check was still on. At 6:50 p.m. NA-A was obswing from the nurse remained on and N6:55 p.m. LPN-D we R6's room while his and failed to responsible.	um Data Set (MDS) 9/8/16, identified R6 required two staff with bed mobility and ual MDS assessment further terview for Mental Status indicating mild cognition DS also identified R6 with no posis and identified R6 had	F 24	instruction that call lights should answered within 5 minutes. And respectful mannor. 2. All residents that depend on a assistance have the potential to affected. 3. Measures and systemic changimprove call light response in tim fashion were: All staff inservices 11/15/16 and 11/16/16 were info facility policy that lights were to be answered within 5 minutes. Ranaudits were done for all shifts on 11-7,8,9,12. Audits will continue for 1 month. 4. Follow up on responses to be discussed at department head with meetings and next QA with finding 5. DON is responsible for task. Caction to be completed 12/20/16	speak in staff for be ges to nely held on rmed of be dom bi-weekly reekly ngs. Corrective		

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F 241	p.m. trained medic observed to walk droom, with the call stop to check on R R6 from the hallwain his room while lot the bed. R6 was no light with repeated his face. At 7:02 p R6, asking him who wanted to get into I that nurse I need sthey come? I've be On 11/1/16, at 7:04 room and approach asked staff if they come and approach asked staff if they come. LPN-D and Now assisted him into both time he activate queried him about When interviewed director of nursing R6's call light responservation on the stated she felt staff the resident call light work further stated staff the resident what the will be back. The D described was a distated it was hard for work done with just better with 4 staff.	ation assistant (TMA)-A was own the 100 wing past R6's light on and TMA-A did not 6. At 7:01 p.m. while observing y, it was noted he was seated ocated in his wheelchair beside oted to be pressing on his call action with an angry look on .m. the surveyor questioned at he needed. R6 reported he oed, stating, "Where the hell is omeone. Why the hell don't en waiting for a while." It p.m. the surveyor exited the need NA-G and LPN-D and could respond to R6's call light. Seation LPN-D stated, Oh great, a sarcastic manner. At 7:10 A-G entered R6's room and ed. R6 waited 40 minutes from ed his call light before staff	F 24					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
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F 241	The quarterly MDS identified R31 with cognition; and minit delusions. The MDS some behaviors to required extensive activities of daily liv. During interview on was questioned wh dignity and respect R31 explained that rush and didn't do a on the evening shift would tell him he didaily. R31 stated his teeth anyway arburden to them. It wown natural teeth, always taken good the reason he still hverbalized that goohim. R31 also state problem responding when he requests the garbage can beside staff get snippy or awill take an excessito call lights; at time get call light responding to get assistant put my call light on have to sit in an incompared to wait that length R31 also verbalized.	ge 3 to find staff for hire. assessment dated 8/24/16, a BIMS of 15, indicating intact mal depression with no Sidentified that R31 exhibited wards others and self and assist of 1-2 staff with all ing (ADL's) except eating. 10/31/16, at 11:21 a.m. R31 ether staff treated him with and R31 responded, "no." staff seem to always be in a all of his cares. R31 stated that during bedtime cares, staff d not need to brush his teeth e tells staff he wants to brush hid staff are resistive, as if is a was noted that R31 has his R31 further stated he had care of his teeth which was had his natural teeth. R31 d oral care was important to d staff seem to have a get to simple tasks; for example, hat staff move his fan and/or e him. R31 described that argue. R31 also stated staff we amounts of time to respond es, it took around an hour to use. R6 stated he uses his call ce with toileting. R6 stated, "I when I am incontinent and I ontinent brief for a long time. If a staff tell him there are others is unable to report the name of	F 2	241		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	COMPLETED			
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F 241	timeframe's to wait meal times and on self-transferred dur assistance, knowing further stated the sit R31 stated this lang towards him but was stated,"They use voword, I don't like it." informed by staff if wanted he would hanight. At completion whether he had repstaff and he indicate. During interview wit 11/2/16, at 10:14 a. aware of any of the SW stated she met and R31 had not vower related to staffin would visit with R31 SW stated R31 wor interview but stated. On 11/2/16, at 12:1 been interviewed at his room and told him to brush his tee occurred on day an stated staff should this was certainly not also stated R31 told bed staff did not was confirmed that R31 desired daily oral cay was necessary to be	d. R31 indicated the worst for assistance were during weekends. R31 indicated he ing long wait times for staff g it may be unsafe. R31 taff swear while caring for him. It guage was not directed soffensive to hear. R31 ulgar language to include the FR31 also stated he had been he didn't go to bed when they are to sleep in his chair all not interview R31 was asked orted any of the concerns to ed he might have told LPN-B. Ith the social worker (SW) on m. she stated she was not concerns addressed by R31. with R31 on a monthly basis piced any of the concerns to no and/or staff attitude but to hear about his concerns. Uld be a reliable person to he did get confused at times. If 2 p.m. SW stated R31 had not R31 verified staff came in im they didn't have time for eth. R31 told the SW this devening shifts. The SW treat resident's with dignity and of the dignified treatment. The SW do her when staff assist him to the shim. The SW also reported that although he are, he felt staff did not think it rush nightly. The SW also reported that oral care was		41			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

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F 241	R31 was unable to involved staff, espename tag. The SW discussion with R3 and filed a Vulneral The SW also confir dislike of staff langhim. During interview on stated R31 had not these dignity issues when his call light is was unaware of R3 staff being rude to I On 11/2/16, at 12:5 (DON) was intervier esponse time durin DON stated she had concerns by the reswas reliable but was might not recall this stated if she would complaints she would complaints she would required extensive toileting, personal hupon staff for transity. When interviewed of stated there is a lor with toileting and she will response time during the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated there is a lor with toileting and she will response to the stated the stated the response to the stated the stated the stated the response to the stated the s	orning. The SW stated that report the names of the cially if they did not wear a reindicated that after 1 she reported the incidents ole Adult report immediately. The Adult report immediately med R31 had expressed his uage (cursing) used in front of 11/2/16, at 12:27 p.m. LPN-B approached her about any of s. LPN-A stated he will tell staff is not answered timely but she in waiting and hour to toilet or nim. 3 p.m. the director of nursing wed about R31's call lighting and other concerns. The d not been made aware of the sident or staff and verified R31 is sometimes demanding and ags correctly. The DON further have been told about the all have handled it. Quarterly MDS assessment entified a BIMS score of 15/15, gnition. The activities of daily isment identified that R29 staff assistance with dressing, nygiene and total dependence	F 2	241				

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F 241	light but was able to the facility to inform R29 indicated this weeks prior and extelephone call, staff assistance. R29 furweek, (she thought was so short staffer residents were drest of the supper meal room dressed in the not think this was rethe dining room dressed in the dining room dressed in reported she was well the toilet and then is stated this was a context of the call light. R29 she had "wet her part of a long time. During a subsequent 1:18 a.m. R29 was drinking coffee and (unable to report the or does not treat more displayed and the facility policy for dated 5/2011, identicall lights would be manner. Procedure:	was unable to reach the call of access her phone, so called in them she needed assistance. Occurred approximately 2 eplained that after the fidid provide her with orther reported the previous it is was a Sunday) the facility do not he weekend that multiple seed in their night clothes prior and were taken to the dining is manner. R29 stated she did ight and she refused to go to essed for bed. Observation on 11/2/16, from a.m. (38 minutes) R29's call be activated and sounding. her wheelchair her room. R29 waiting for staff to assist her to into her recliner. R29 also common occurrence to wait an of time for staff to respond to further indicated in the past, ants" because she had to wait that interview on 11/2/16, at seated in the wheelchair indicated there was a staff ite name) that "isn't very nice,	F 24	.1			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY PLETED
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F 244 SS=E	not to exceed 15 m 3. Time to answer a requests and reque bathroom are not to possible. 4. Call lights should addressing the stat 483.15(c)(6) LISTE GRIEVANCE/RECO When a resident or must listen to the vi grievances and rec and families concer	general call light requests are inutes, when possible. In emergency call light for ests for assistance in the exceed two minutes, when the beturned off promptly when ed need in a resident room. N/ACT ON GROUP	F 24			12/13/16
	by: Based on documer facility failed to come related to the ongoi light response time group over the past potential to affect a the facility. Findings include: During interview on stated facility staff of concerns expresse R7 indicated concerns ocial worker (SW) meeting but no upd	nt review and interview the imunicate actions taken ing complaints of delayed call expressed by the resident 12 months. This has the ill 29 residents who reside in 11/1/16, at 4:17 p.m. R7 don't follow through with d at resident council meetings. In are written down by the previewed at next month's at related to what actions are of the council. R7 further stated		1. R7 visited with concerns with canot being answered timely. He statusually in the evening when he wawith his CPAP.Resident informed the PM staff aware of his need. 2. All residents of the facility are potentially affected by the failure of follow up on residents complaints. 3. S/S and DON have discussed in DON to be present at resident could. Staff attending resident group we to include the DON along with S/S dietary so that issues may be addrested promptly. Documentation of same done by DON and S/S promptly affollowup. DON and S/S will follow resident concerns promptly to imposite the	tes its nts help hat the f staff to eed for ncil. ill start and essed will be ter up with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
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F 244	staffing levels and be an ongoing concup all the time". The Resident Courreviewed for the provided for the	call light response continues to cern, responding, "it's brought neil meeting minutes were evious 12 months and s on-going resident complaints light response as noted in the long time for call lights. of waiting for call lights during not answered very quickly and	F 24	resident satisfaction. Result reviewed at QA meetings. 5. DON and S/S are respon followup and documentation date 12-20-16	sible for		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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F 244	Continued From pa	ge 9	F 24	4	
	director of nursing (copy of the resident aware of the concerelated to poor call DON indicated only manager attended confirmed she had updates to the cour to call light respons	on 11/3/16, at 11:43 a.m. the DON) stated she receives a tocuncil minutes and was resthat residents expressed light response by staff. The the SW and the dietary council meetings and not communicated any notil with their concerns related the times.			
F 282 SS=E	indicates Resident communication between as a source of quality of life and caresident speak up in change. Staff mem their monthly meetin dietary manager, ar 483.20(k)(3)(ii) SEF	Council can improve ween staff and residents, of new ideas, help identify are issues, and help individual in a collective voice to effect abers who assist residents in angs include social services, and director or (sic) nursing.	F 28	2	12/13/16
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of			
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview and document illed to provide personal cares are plan for 6 of 10 residents R14, R9) reviewed.		1. Corrective action for cited reside R3, R5, R20, R14, R19, had facial h groomed when noted. R6 was set u a dental appointment. Staff instructe toilet R20 every 2 hours or less if ne R20 is able tell staff when needs to	nair p with ed to eeded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245552	B. WING				C 03/2016
	PROVIDER OR SUPPLIER AL MANOR OF BALA	гоп		Н	TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		,0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	The quarterly Minimassessment dated extensive assistant plan, last revised for identified R3 had a and bathing related care plan further ideand impaired cognistaff assist for bathing initial observation in the facial hair on his morning; however a seated in the his morn	num Data Set (MDS) 9/8/16, identified R3 required se with grooming. R3's care r grooming, on 6/24/16 self care deficit with grooming to dementia and arthritis. The entified R3 had memory loss tion and was dependent upon	F 2	282	bowel movement not always for vo R5, R14 both had nail care done by licenced staff as are diabetic. R9 caplan is now current with NAR assig to reflect current plan of care. 2. All residents well being has the potential to be affected by non adhous of care plans. 3. All nursing staff have been instruthat care plans need to be followed meeting held 11/15/16, 2016. 4. Changes to prevent recurrence on 11-10-16 with nail care and facial audits daily for 1 week by assigned Audits will continue weekly for 1 may all nursing staff informed of resider plan per toileting in report and during staff meeeting on 11-15, 11/16/201 Toileting care plans for residents we assessment changes as noted by and RN nurse will be placed on state assignment sheets and kept currer also be addressed at nursing meet the 11/30/2016. Findings to be followed to QA. 5. Responsible party DON, MDS notes.	erence ucted I on started al hair staff. onth. nt care ng all 6. ith MDS ff nt. Will ing on wed up	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	` ´cor	(X3) DATE SURVEY COMPLETED	
		245552	B. WING _			C / 03 / 2016	
	PROVIDER OR SUPPLIER AL MANOR OF BALA	TON		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 282	assigned. NA-D ver have her facial hair morning. At 9:38 a it was verified R3 h removal/grooming confirmed she had have provided the growth all activities of identified R6 require with all activities of identified R6 free or R6's care plan revisidentified R6 with a related to the use oplan identified staff brushing his dentur own teeth. During initial observation it was noted that mather lower gum and protruding from the evidence of decay afront of the lower gum were noted to be crexcessive food debut During interview with R6 stated staff were cares but they forgother was noted that mather than the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding interview with R6 stated staff were cares but they forgother was noted that mather than the lower gum and protruding interview with R6 stated staff were cares but they forgother was noted that mather than the lower gum and protruding interview with R6 stated staff were cares but they forgother was noted that mather than the lower gum and protruding interview with R6 stated staff were cares but they forgother was noted that mather than the lower gum and protruding from the evidence of decay afront of the lower gum and protruding interview with R6 stated staff were cares but they forgother was noted than the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the evidence of decay afront of the lower gum and protruding from the lo	rified she noted that R3 did not removed/shaved that .m. during interview with NA-F ad not received facial hair during the bath. NA-F not shaved R3 but should grooming as expected. ssessment dated 9/8/16, ed extensive assist of two staff daily living (ADL's) and also f any oral or dental concerns. sed care plan dated 9/21/16, an alteration in dental status f upper dentures. The care would provide oral hygiene by e and cueing him to brush his vation of R6 on 10/31/16, at noted to have natural teeth on hat were missing and broken. of R6 on 11/1/16 at 4:35 p.m. ultiple teeth were missing on that teeth were somewhat oral cavity. There was at the gum line of 2 teeth in the lums R6's lower natural teeth acked, discolored and had ris. th R6 on 11/2/16 at 8:11 a.m. the supposed to do his oral of sometimes. R6 stated staff his dental cares last evening	F 28	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245552	B. WING	B. WING			C 11/03/2016	
	PROVIDER OR SUPPLIER AL MANOR OF BALA	гоп		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
F 282	R20's significant chidentified R20 requistaff with toileting. identified R20 with a incontinence related from dementia, psy immobility. The caratoileting schedule to During initial observation as noted to be a pathe middle of room. observation, traine (TMA)-A was made entered R20's room R20 was dependent to toilet. During observation a.m. R20 was observation in her During observation in her During observation at 6:58 a.m. R20 was eated in hallway by R20 was assisted of 6:15 a.m. at which to 11/2/20 at 7:32 dining room and play wheelchair. On 11/2/16, at 9:02 the dining room at to 11/2/20, at 9:21 on 11/2/20, at 9:21	ange MDS dated 8/12/16 red extensive assist of two R20's care plan dated 8/18/16, an alteration in bladder d to functional impairment chotropic drug use, pain and e plan identified R20 had a b be toileted every two hours. vation of R20 on 10/31/16, at seated in her wheelchair in her bathroom and room. There buddle of urine on the floor in At the time of the d medication assistant aware of the observation and a to assist R20. TMA stated t on staff and mechanical lift of cares on 11/2/16, at 6:45 rved seated in hallway by er wheelchair with eyes closed. of morning cares on 11/2/16, as observed seated in the y nurses station. NA-B stated but of bed at approximately time she was toileted. a.m. R20 was wheeled into aced seated at table in her a.m. R20 remained seated in	F 2	82				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	towards the exit doo On 11/2/16, at 9:2 out of dining room a station. R20 utilized the wheelchair. On 11/2/16, at 9:26 wheelchair looking the hallway by nurs On 11/2/16, at 9:46 the bathroom at the hairdresser was wa stated staff needed was fixed. R20 was minutes after her as gotten up. After toile moderately wet whe voided some when During observations and again on 11/2/ fingernails were obs dark debris under the Review of R5's Cur 10/12/16, included Review of R5's qua (MDS) assessment had a Brief Interview score of 5 indicating and needing extens member with perso Review of R5's care	4 a.m. R20 wheeled herself and into hallway by nurses her hands and feet to propel a.m. R20 was seated in her at newspaper while seated in e station. 5 a.m. NA-D assisted R20 to a nurses station as the iting to do R20's hair and to toilet R20 before her hair toileted 3 hours and 30 seistance with toileting when eting NA-D stated R20 was en toileted and in addition, toileted. 5 on 10/31/16, at 11:10 a.m., 16, at 1:14 p.m. R5's served to be long, jagged with the nail on both hands. 10 nulative Diagnosis List dated diagnosis of diabetes mellitus. 11 rterly Minimum Data Set dated 9/19/16, indicated R5 w for Mental Status (BIMS) g severe cognitive impairment sive assistance of one staff	F 2	282			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY IPLETED
		245552	B. WING				C 03/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	and required staff grooming. When interviewed of indicated R5's nail of days as R5 required included R5 had diawas only provided by follow-up interview a.m. confirmed R5's weekly by licensed. Review of R5's treat 2016, included a nufingernails weekly of mornings). Review indicated nail care in 10/31/16, but R5's jagged with notables. During interview and 1:17 p.m. with NA-fingernails were longunder the nail. During interview on DON indicated she nails to be trimmed nursing orders and. During initial interview on 11/1/16, at 1:49 p.m. jagged fingernails were possible. The girl did indicated she did not R14's nails were possible.	assistance with bathing and on 11/2/16, at 7:15 a.m. NA-B care is completed on bath d assistance. NA-B further abetes and therefore nail care by the licensed nurses. A with LPN-B on 11/2/16, at 7:33 s nail care is performed staff/nurse. Attent record dated October arising order to trim R5's on bath days (Monday of the documentation had been completed on hails continued to be long, a debris on 11/2/16. It was confirmed R5's by the licensed nurse per		882			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G) COM	E SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON				STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282		ge 15 11/2/16, at 7:15 a.m. NA-B gernails should be cleaned	F 28	2		
	indicated R14 had a severe cognitive im extensive assistant hygiene needs.	mission MDS dated 8/9/16, a BIMS score of 4 indicating pairment and requiring ce of 1 staff with personal				
	Review of R14's care plan dated 9/21/16, directed NA to do nail care weekly on bath days (Friday morning) and requires extensive assistance of 1 staff with grooming.					
		ath Report dated 10/28/16, did or the residents fingernails had				
	DON indicated she fingernails to be trir	11/3/16, at 11:40 a.m. the would have expected R14's mmed per resident's liking on eeded as directed on the plan				
	nail care includes d trimming. It directs and under each nai	s revised 10/2010, indicates aily cleaning and regular to remove dirt from around I with an orange stick, trim al shape, and to smooth the				
	severe cognitive im required total assist	dated 8/25/16, indicated pairment per staff interview, tance of two staff for transfers ontinent of bowel and bladder.				

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· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG	COMPLETED		
		245552	B. WING _		11	C / 03/2016	
	NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON			STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Review of R9's carrinstructed nursing turinary incontinence with the use of a He to lift) and two staff. During interview on states R9 gets up of lift (a mechanical states but after that is transand requires only of incontinent briefs. During interview on stated R9 is placed breakfast using the During interview on indicated R9 is toild lift once/day shift. During interview on stated R9 transfers commode before a stated a Stand lift heares and R9 had a prior to the breakfa information per R9' and the care list. During interview on stated R9 is to be to is checked and chaincontinence care. occurred on 8/27/1 on a commode had confirmed the staff charting record did	e plan updated 8/27/16, to check and change for e every 2 hours and transfer oyer (mechanical device used	F 28	32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245552		B. WING) 3/2016	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON			H	TREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115			
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	plan and NA's were related to transfers When interviewed of DON verified staff is had not been follow directed. The DON the restorative sheet to be accurate per late of the transfers. The facility's policy plans-Comprehens care plan interventic consideration of the resident's problem. Assessments of resplans are revised as resident and reside 483.25(a)(3) ADL ODEPENDENT RES A resident who is used all viving receives maintain good nutricand oral hygiene. This REQUIREMENT by: Based on observative review the facility f	and toileting. on 11/3/16, at 11:15 a.m. the had incorrect information and ring the plan of care as confirmed she would expect et and care lists used by NA's R9's care plan. for Care ive revised 10/2010, indicates ons are designed after careful et relationship between the areas and their causes. Sidents are ongoing and care is information about the nt's condition change.	F 282			12/13/16	
		unable to perform grooming ne without extensive staff		diabetic. R6 has a dental appointment made as requested. 2. All residents that depend on staff cares are at risk to be affected if canot being followed.	f for		

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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON			1	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	
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F 312	assessment dated Brief Interview for N 3, indicating severe also identified R3 re of staff with groomi R3's care plan, last 6/24/16, identified t with grooming and and arthritis and wa assistance with bat care plan further ideand impaired cogni During initial observation, at 11:33 a. long facial hair on hair the facial hair was conversation. During observation was seated in the haurses station. this morning; howe present. When into observation, R3 staface, was unaware indicated she would stated she did not ke shave her. During interview with at 7:27 a.m. she stafair nor perform fin she frequently notice.	num Data Set (MDS) 9/8/16, identified R3 with a Mental Status (BIMS) score of cognition impairment and equired extensive assistance ng. revised for grooming, on hat R3 had a self care deficit bathing related to dementia as dependent upon staff hing and grooming needs. The entified R3 had memory loss	F 312	3. Policies related to grooming and care were reviewed at staff meetin 11/15,16,/2016. They will also be reat Nursing meeting on 11/30/16. 4. Nail care and facial hair care on females were audited on 11/10/16. were done daily for 1 week and wildone weekly for a month. Dental assessments carried out by MDS rewill be reviewed for 1 month for fol for needed dental visits. Findings to followed with at QA. 5. DON, Licensed nurses, MDS nuresponsible. Completion by 12/13/19/19/19/19/19/19/19/19/19/19/19/19/19/	g on eviewed Audits I be nurse low up o be

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
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F 312	During interview on assistant (NA)-D st provide facial hair or resident baths. NA R3 her bath this massigned. NA-D ve have her facial hair morning. At 9:38 a it was verified R3 h removal/grooming confirmed she had have provided the offurther identified a mild cognitive impassion. Further identified R6 free of the confirmed R6 free offurther identified R6 free of	a 11/2/16, at 9:33 a.m. nursing ated staff were expected to grooming and nail care during and nail care during and part of the property of the		2			
	identified R6 with a related to the use of plan identified staff	sed care plan dated 9/21/16, n alteration in dental status of upper dentures. The care would provide oral hygiene by the and cueing him to brush his					
	10:39 a.m. R6 was	vation of R6 on 10/31/16, at noted to have natural teeth on that were missing and broken.					
	it was noted that m the lower gum and protruding from the evidence of decay	of R6 on 11/1/16 at 4:35 p.m. ultiple teeth were missing on that teeth were somewhat oral cavity. There was at the gum line of 2 teeth ne lower gums R6's lower					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245552	B. WING _		11	C / 03/2016	
	NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		700/2010	
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F 312	natural teeth were in discolored and had During interview wir R6 stated staff were cares but they forget failed to complete in (11/1/16) and this in During observation p.m. R20 was located to the nurses' static long facial hairs on which was visible diresident. During observation a.m. R20 was observed in the nurses' were visible during. During interviews was at 12:47 p.m. staff presence of R20's R20 had a bath the facial hairs should the bath. Both staff done. During interview wire (DON) on 11/2/16, staff should provider resident's on bath of the facility policy for revised 10/2010, id	noted to be cracked, excessive food debris. th R6 on 11/2/16 at 8:11 a.m. e supposed to do his oral of sometimes. R6 stated staffnis dental cares last evening norning (11/2/16). of cares on 11/1/16, at 4:06 ed in her wheelchair adjacent on. R20 was noted to have her chin and sides of face uring interaction with the of cares on 11/2/16, at 6:58 erved seated in her wheelchair station and long facial hairs interaction with the resident. with NA-C and NA-F at 11/2/16, were questioned about the facial hair. Both NA's stated morning of 10/31/16 and the nave been hair clipped during confirmed it had not been th the director of nursing at 2:00 p.m. it was verified e shaving services to all days as needed. or "Shaving the Resident", entified the purpose of the ote cleanliness and to provide	F 31	2			

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F 312	special needs of th 2. Assemble equip The policy did not i shave residents or residents, but just i shaving. No other submitted by facility. During observation and again on 11/2/fingernails were obdark debris under to the Review of R5's Cur 10/12/16, included Review of R5's qua (MDS) assessmen had a Brief Interview score of 5 indicatin and needing extensmember with person Review of R5's car R5 with a functional and required staff grooming. During interview or indicated nail care days and R5 required included R5 had di was only provided Follow-up interview (LPN)-B on 11/2/16 nail care is done where the service of R5's treated to the service o	e resident. ment and supplies as needed. nclude directions for when to how to shave female ncluded basic guidelines for colicy for shaving was y. non 10/31/16, at 11:10 a.m., /16, at 1:14 p.m. R5's served to be long, jagged with the nail on both hands. mulative Diagnosis List dated I diagnosis of diabetes mellitus. arterly Minimum Data Set t dated 9/19/16, indicated R5 w for Mental Status (BIMS) g severe cognitive impairment sive assistance of one staff	F 31	2				

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	NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON			STREET ADDRESS, CITY, STATE, ZIP HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 312	mornings). Review indicated nail care I 10/31/16; however, jagged with notable During interview an 1:17 p.m. with NAwere long, jagged a nail. During interview with 11:40 a.m. it was in nails to be trimmed nursing orders and During initial interviting initial interviting indicated she did not R14's nails were portion of R14's nails were portion of R14's addindicated R14 had a severe cognitive important extensive assistant hygiene needs. Review of R14's can NA to do nail care with notable and care wit	of the documentation had been completed on R5's nails remained long and debris on 11/2/16. d observation on 11/2/16, at B, confirmed R5's fingernails and had dark debris under the the the DON on 11/3/16, at dicated she expected R5's by the licensed nurse per as needed. ew and observation of R14 on a. R14 was observed to have with sharply cut angles. R14 them in a hurry". R14 of like how they were trimmed. It like how they were trimmed. It like how they worn. on 11/2/15, at 6:59 a.m. R14's ged with sharply cut angles. mission MDS dated 8/9/16, a BIMS score of 4 indicating pairment and requiring the of 1 staff with personal of the plan dated 9/21/16, directed weekly on bath days (Friday red extensive assistance of 1	F3	812			
		th Report dated 10/28/16, did r the residents fingernails had					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245552	B. WING		C 11/03/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	11/03/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 312	indicated R14's fing trimmed on bath da	11/2/16, at 7:15 a.m. NA-B gernails should be cleaned and lys.	F 3	12	
F 315 SS=D	DON indicated she fingernails to be trin 10/28/16, and as not the facility's policy Fingernails/Toenails nail care includes d trimming. It directs and under each nai fingernails in an ovanails with a nail file	titled Care of s revised 10/2010, indicates aily cleaning and regular to remove dirt from around I with an orange stick, trim al shape, and to smooth the or emery board. HETER, PREVENT UTI,	F 3	15	12/13/16
	assessment, the factoresident who enters indwelling catheter resident's clinical contact catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder excent store.			
	by: Based on observat review the facility fa services for 2 of 2 r	NT is not met as evidenced ion, interview and document illed to provide timely toileting esidents (R20, R31) reviewed assistance with toileting needs.		R20, R31 toileting plans indicate bladder incontinence with a toileting Staff instrucucted to toilet according POC. R31 does not always allow staff.	g plan. g to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245552	B. WING _		11	C / 03 / 2016
	PROVIDER OR SUPPLIER	гон		STREET ADDRESS, CITY, STATE, ZIP C HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		70072010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 315	(MDS) assessment required extensive a toileting. The MDS frequently incontine toileting program ar previous toileting pl had reduced incont plan. R20's bladder asse from 8/13/16-8/15/1 identify the need to toilet when toileted on some occasions at times of toileting, R20 was able to fin. R20's care plan dat an alteration in blad functional impairmed psychotropic drug us care plan identified to be toileted every. During initial observed 2:20 p.m. R20 was her room and a pure floor in the middle cobservation, trained (TMA)-A was made entered R20's room R20 was dependented support of the middle of	ange Minimum Data Set dated 8/12/16, identified R20 assist of two staff with further identified R20 was ant of urine and did not have a and identified there had been a an which demonstrated R20 inence with the implemented ssment (3 day toileting log 6) identified R20 was able to void and was able to void in every two hour. Even though R20 was incontinent of urine (documented-small amount), ish voiding when toileted. ed 8/18/16, identified R20 with lder incontinence related to ent from dementia, use, pain and immobility. The R20 had a toileting schedule two hours. Vation of R20 on 10/31/16, at seated in her wheelchair in the ldle of urine was noted on the of room. At the time of the lamedication assistant aware of the observation and into assist R20. TMA-A stated to n staff and a mechanical lift let. TMA-A verified the urine	F 3:	toilet as planned and denies toilet even though he can be 2. All residents with inconting affected with worsening incompleting plans are not follow 3. All direct care staff inform following toileting plans of con 11/15,16/2016. 4. Monitoring to be done with audits on these 2 affected or Compliance to be evaluated Manager for progress on eigimprovment or decline and plan changes as needed. A necassary actions with nursum meeting on 11/30/2016. Audito be discussed at QA meets. Nurse manager responsi Completion date 12/13/2016.	e already wet. nence may be ontinence if wed. ned of care at meeting th toileting residents x 3. d by Nurse ther make care also will review sing at nusing dits at findings tings ble party.	9

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		, ,	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245552	B. WING				C 03/2016
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP OF HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	CODE	11/0	33/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 315	During observation p.m. R20 was seate station and was not present when stand During observation p.m. R20 was assist the nurses station. assisted R20) verification when taken in she also noted the was unsure where During observation a.m. R20 was seate station in her wheel 6:58 a.m. R20 remain the same location time, NA-B stated Fapproximately 6:15 time. At 7:32 a.m. dining room and se R20 remained seat same table. At 9:21 by slowly wheeling At 9:24 a.m. R20 whallway located by a.m. R20 remained looking at newspap hairdresser, who we stated staff needed arrived in the beaut assisted R20 into the nurses station. R20 minutes (6:15 a.m. assisted with morniprovided, NA-D corresponding to the station of the s	of cares on 11/1/16, at 4:06 and in the hallway by nurses and to have a strong urine odor ding nearby. of cares on 11/1/16, at 5:05 ated to the toilet located near Nursing assistant (NA)-A (who ed R20 was incontinent of the bathroom and stated strong urine odor present but it was from. of cares on 11/2/16, at 6:45 and in the hallway by nurses' chair with eyes closed. At ained seated in the wheelchair in. When interviewed at this R20 was assisted out of bed at a.m. and was toileted at that R20 was wheeled into the ated at a table. At 9:02 a.m. and in the dining room at the a.m. R20 left the dining room herself toward the exit door. Wheeled herself into the the nurses' station. At 9:26 seated in her wheelchair are in the same location. The as waiting to fix R20's hair, to toilet R20 before she y shop. At 9:46 a.m. NA-D he bathroom located near the 0 was toileted 3 hours and 30 -9:46 a.m.) after she was ng cares. After toileting was infirmed R20 was moderately and also verified R20 voided	F3	315			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245552	B. WING				C 0 3/2016
	PROVIDER OR SUPPLIER	TON		Н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 14 EAST PO BOX 219 ALATON, MN 56115	11/	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	nursing assistant (Nability to void in the remained dry when schedule. When interviewed oregistered nurse (Ratwo hour toilet schetoilet her at a minimal minimal minimal matter). The quarterly MDS identified R31 with cognition; and minimal minimal minimal matter and minimal minimal matter and minimal matter and minimal matter and minimal minimal minimal matter and minimal minimal matter and minimal mi	on 11/2/16, at 6:50 a.m. NA)-D stated R20 had the toilet and sometimes toileted on a two hour on 11/2/16, at 1:16 p.m. N)-B verified R20 was on a dule and verified staff should num of every two hours. assessment dated 8/24/16, a BIMS of 15, indicating intact mal depression with no Sidentified that R31 required 1-2 staff with all activities of except eating. The MDS and R31 was frequently bre episodes of urinary list 1 episode of continent 10/31/16, at 11:21 a.m. R31 ether staff treated him with and R31 responded, "no." I take an excessive amounts to call light; at times, it took get call light response. R6 call light to get assistance with , "I put my call light on when I I have to sit in an incontinent at That makes me feel awful he had to wait that length of k. R31 indicated the worst	F3	315			
	meal times and on	for assistance were during weekends. on 11/2/16, at 12:53 p.m. the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		E SURVEY PLETED
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NAME OF I		245552	B. WING _	OTDEET ADDRESS SITV STATE 7/D OODE	11/0	03/2016
	PROVIDER OR SUPPLIER AL MANOR OF BALA	гоп		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	response time and	ge 27 DON) about R31's call light stated if she would have been plaints she would have	F 3	15		
F 353 SS=E	Continence and Inc Management. The passessments would identify staff's respondentiventions were fareful.	followed. No other policy was ENT 24-HR NURSING STAFF	F 3	53		12/13/16
	provide nursing and maintain the highes and psychosocial w	ve sufficient nursing staff to I related services to attain or it practicable physical, mental, ell-being of each resident, as dent assessments and care.				
	numbers of each of personnel on a 24-h	ovide services by sufficient the following types of nour basis to provide nursing in accordance with resident				
		d under paragraph (c) of this urses and other nursing				
	section, the facility	d under paragraph (c) of this must designate a licensed charge nurse on each tour of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245552	B. WING		11/0) 3/2016
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
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F 353	This REQUIREMEI by: Based on observat failed to ensure suf meet resident need grooming, oral care light response for 8 R6,R9, R14, R20, I potential to affect a Findings include: Based on observat review the facility facall light requests a manner for 3 of 3 reidentified staff did r Refer to F241. Based on documer facility failed to conrelated to the ongoi light response time group over the pass potential to affect a the facility. Refer to Rased on observat review the facility fa as directed by the conference with the facility fa so directed by the conference with the facility fa so directed by the conference with the facility fa so directed by the conference with the facility fa so directed by the conference with the facility fa for 5 of 10 resident reviewed who were	tion and interview the facility ficient staffing was available to its related to appropriate and timely call of 29 residents (R3, R5, R29, R31). This had the ill 29 residents in the facility. It ion, interview and document alled to promptly respond to and/or speak in a respectful esidents (R6, R31, R29) who not provide dignified care. Interview and interview the influence actions taken in geomplaints of delayed call expressed by the resident at 12 months. This has the ill 29 residents who reside in the provide personal cares are plan for 6 of 10 residents (R14, R9) reviewed. Refer to interview and document alled to provide grooming cares as (R3, R6, R20, R5, R14) anable to perform grooming ne without extensive staff	F 353	1.Corrective action as it applies to R5, R16, R20, R31. Residents inf that facility will supply staffing to make their needs. 2.This has the potential to affect a residents in the facility that depend facility for needs. 3.Facility will continue to recruit make staffing. Minimum staff needs with residents is 4 NARs. If we are downless residents it is 3 NARs along who will the same than the spends the first 3 hours and the last hour of her shift as an NAR. Night NAR. This is adequate to meet resoneds and is over the minmum resonate staffing levels. IF staffing is readequate facility will reject new resonate staffing is adequate. (Facility which continue to use pool staff when awholds the staffing staff at nurses means on 11/30/2016 about meeting residneeds. Charge nurses will assist in NAR shifts as needed. Facility will educate nursing staff at nurses means and staffing guidelines. All also informed of staffing concerns guidelines on 11/15/2016 and 11/1 DON and S/S will re-interview direaffected residents by 12/8/2016 for being met. 4.Residents staffing issues and aucares will be discussed at weekly department head meetings and Quitermine if we have adequate staff. Responsible parties are DON are staffing is a pool of the staff of	ormed leet II don ore NAR 33 in to 5 with the mishift. It is shave 1 sidents quired not is shift in filling leeting dent staff and 6/2016. Ctly rineeds lidits of A to fing.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245552	B. WING				C 03/2016
	PROVIDER OR SUPPLIER AL MANOR OF BALA	TON	,	Н	TREET ADDRESS, CITY, STATE, ZIP CODE IIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	review the facility faservices for 2 of 2 r who required staff a Refer to F315 Additional Interview nursing an interview nursing assistant (N NAs working from 2 provide care for 29 arrived to assist. T 2 NAs working can depending on the dwilling to come in. a nurse on duty but everyone. When interviewed of indicated at times the or working short. N is normally 4 NAs a example, this morn assistant on duty-1 persons on the 200 was according to the "there is not enough and indicated short weekly. NA-C confresidents had urinal	on, interview and document tiled to provide timely toileting esidents (R20, R31) reviewed assistance with toileting needs.	F3	853	Administrator. Completetion date 12/13/2016.		
	(restorative) indicat been developed an programs provided	on 11/3/16, at 8:32 a.m. NA-J ed a restorative program had d provided a list detailing the for each resident. NA-J ough he was scheduled as the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245552	B. WING _		11	C / 03/2016	
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 353	to the floor to help NA-J indicated this times/pay period. I with consistently im restorative program restorative duties a hour shift with mini other NAs.	role, he would be re-assigned f there was a staff shortage. occurred a couple of NA-J indicated this interferes plementing each resident's n. NA-J indicated the ssignment normally filled an 8 mal assistance provided to the	F 35	53			
	director of nursing R6's call light responsible stated she felt staff resident call light with further stated staff the resident what the will return. The DC the staff to get all onurses aides scheduler.	on 11//2/16, at 12:53 p.m. the (DON) was questioned about onse time during the evening of 11/1/16. The DON should respond to any ithin five minutes. The DON should at least stop by and ask ney need and notify them they DN also stated it was hard for f the work done with just three duled as it was better with 4 d she had frequent call- ins to hire.					
	8:47 a.m. the DON response time for a	nt interview on 11/03/2016, at indicated appropriate acknowledge of a resident's inutes and response within 15					
	indicated The Direct the Nurse supervisions minimum, is responsible and staff residents; providing necessary or approximately ap	y from Personnel and Staffing stor of Nursing Services and/or or/Charge Nurse, as a nsible for: Assigning work fing to meet the needs of g direct resident care as priate, and other tasks and become necessary.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		245552	B. WING _		11/0) 3/2016
	ROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE

PRINTED: 12/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		TE SURVEY MPLETED	
		245552	B. WING_		11	/02/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	INITIAL COMMEN	TS	K 00	00			
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST MS-2567 FORM WILL BE CATION 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.						
	Minnesota Departicular Fire Marshal Division the time of this survivas found not to builth the requirement Medicare/Medicaid 483.70(a), Life Saredition of National	e Survey was conducted by the ment of Public Safety, State ion, on November 2, 2016. At rvey, Colonial Manor of Balaton be in substantial compliance ents for participation in d at 42 CFR, Subpart fety from Fire, and the 2012. Fire Protection Association afety Code (LSC), Chapter 19 are Occupancies.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (F	OR THE FIRE SAFETY		EPC	C		
	Health Care Fire I State Fire Marsha 445 Minnesota St St. Paul, MN 5510	l Division reet, Suite 145					
BORATOR'	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

Facility ID: 00982

11/28/2016

Electronically Signed

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245552	B. WING			11/02/2016	
	PROVIDER OR SUPPLIER			н	FREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 14 EAST PO BOX 219 ALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	ΚŒ	000	2		
	Angela.Kappenma	nitney@state.mn.us> and			3		
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:					
	A description of to correct the defication	what has been, or will be, done iency.					
	2. The actual, or p	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
	1973, is one-story	Balaton was constructed in in height, has no basement, is protected and was determined 1) construction.					
	detection in the co corridors which is department notific	ire alarm system with smoke rridors and spaces open to the monitored for automatic fire ation. The facility has a s and had a census of 29 at					
	NOT MET as evid	at 42 CFR, Subpart 483.70(a) is enced by: • Occupancies - Construction	К	133			12/25/16
	Multiple Occupand	cies - Construction Type occupancies are in accordance					

PRINTED: 12/05/2016 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF ND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY
35		245552	B. WING		11/02/2016	
	VIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZII HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
wiff coo but accook acco	nstruction type is ilding, unless a 2 cordance with 8. nstruction type is in the construction of the sed on the story ilding in accordance with 18.1.3.5, 19.1.3.5, as STANDARD ased on observaled to maintain a accordance with uld affect 29 out ultiple Occupance here separated of the 18/19.1.3.2 or instruction type is instruction type is instruction of the sed on the story ilding in accordance with 8. Instruction of the insed on the story ilding in accordance with 8. Instruction of the ised on the story ilding in accordance with 18/19.1.6.1 The construction in the construction in the story ilding in accordance will in accordance with 8. Instruction of the ised on the story ilding in accordance with 8. Instruction of the ised on the story ilding in accordance will	18/19.1.3.4, the most stringent is provided throughout the 2-hour separation is provided in 2.1.3, in which case the 3 determined as follows: type and supporting health care occupancy is in which it is located in the nce with 18/19.1.6 and Tables type of the areas of the the other occupancies shall be cable occupancy chapters. 8.2.1.3 is not met as evidenced by: tion and interview, the Facility a 2-hour separation is provided 8.2.1.3. The deficient practice of 29 residents. ies - Construction Type occupancies are in accordance 18/19.1.3.4, the most stringent is provided throughout the 2-hour separation is provided in 2.1.3, in which case the se determined as follows: type and supporting health care occupancy is in which it is located in the ance with 18/19.1.6 and Tables type of the areas of the the other occupancies shall be cable occupancy chapters.	K	1. Maintenance staff will neccessary repairs (fire of up all penatrations in the seperation wall between of Balaton and the Assist in accordance with 18/19/18/19.1.3.4. 2. Completion date 12/25 3. Correction responsibility to prevent a reoccurrency deficiency will be by the Maintenance Director, Disupervised by Executive Ness.	caulking) to seal 2 hour fire Colonial Manor ted Living Facility 0.1.3.2 or 6/2016. ity and monitoring e of the Facility ouglas Hall as	

Facility ID: 00982

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	01 - MAIN BUILDING 01	COMPLETED		
		245552	B. WING		11/0	02/2016	
	PROVIDER OR SUPPLIER	TON	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 133	on 11/02/2016, obs penetration around above the lay-in ce separation wall bet Assisted Living Fac This deficient pract	veen 10:00 AM and 2:00 PM servation revealed a a sprinkler pipe was observed iling in the 2 hour fire ween Colonial Manor and the	K 133				
K 321 SS=E	discovery. NFPA 101 Hazardo Hazardous Areas - 2012 EXISTING Hazardous areas a having 1-hour fire r fire rated doors) or system in accordant approved automati option is used, the other spaces by sh doors in accordant self-closing or auto have nonrated or f that do not exceed the door. Describe the floor hazardous areas th 19.3.2.1 Area Seperation Na a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten	Enclosure Enclosure Are protected by a fire barrier resistance rating (with 3/4-hour an automatic fire extinguishing nce with 8.7.1. When the c fire extinguishing system areas shall be separated from noke resisting partitions and ce with 8.4. Doors shall be smatic-closing and permitted to iteld-applied protective plates 48 inches from the bottom of and zone locations of nat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms er than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) in Rooms	K 321			12/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		ATE SURVEY OMPLETED	
		245552	B. WING_		11/0	2/2016	
	PROVIDER OR SUPPLIER AL MANOR OF BALA			STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 321	(over 50 square feg. Laboratories (if Hazard - see K322 This STANDARD Based on observation failed to maintain help a fire barrier harating. The deficien of 29 residents. Hazardous Areas 2012 EXISTING Hazardous areas a having 1-hour fire fire rated doors) or system in accordan approved automat option is used, the other spaces by strong and the doors in accordant self-closing or automated or final to not exceed the door. Describe the floor hazardous areas to 19.3.2.1 Area Seperation Na. Boiler and Fuelb. Laundries (large c. Repair, Maintend. Soiled Linen Role. Trash Collection (exceeding 64 galf. Combustible Sto (over 50 square feg.)	et) classified as Severe (0) is not met as evidenced by: ation and interview, the Facility nazardous areas are protected ving 1-hour fire resistance nt practice could affect 15 out - Enclosure are protected by a fire barrier resistance rating (with 3/4-hour r an automatic fire extinguishing nce with 8.7.1. When the ic fire extinguishing system areas shall be separated from moke resisting partitions and ce with 8.4. Doors shall be omatic-closing and permitted to field-applied protective plates if 48 inches from the bottom of and zone locations of hat are deficient in REMARKS. Automatic Sprinkler //A -Fired Heater Rooms er than 100 square feet) hance, and Paint Shops homs (exceeding 64 gallons) har Rooms lons) orage Rooms/Spaces eet) classified as Severe	K 32	1. Maintenance staff will ma appropriate repairs (fire caull accordance with 8.7.1 and 8. 2. Completion date 12/25/20 3. Correction responsibility a to prevent a reoccurrence of deficiency will be by the Faci Maintenance Director, Dougl supervised by Executive Directors.	king) in .4 16. nd monitoring the lity las Hall as		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245552	B. WING	_		11/0	2/2016
	PROVIDER OR SUPPLIER			ŀ	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 321	Continued From p	page 5	KS	321			
	Findings include:					ŀ	
	on 11/02/2016, ob	tween 10:00 AM and 2:00 PM servation revealed penetrations vall within the Oxygen Storage					
	Maintenance Dire	ctice was verified by the Facility ctor. arm System - Testing and	K:	345			11/2/16
	A fire alarm system accordance with a with the requirement Electric Code, and and Signaling Code	n - Testing and Maintenance m is tested and maintained in an approved program complying ents of NFPA 70, National d NFPA 72, National Fire Alarm de. Records of system tenance and testing are readily , and NFPA 25					
	Based on docum the Facility failed Alarm System in a National Electric (Fire Alarm and Si	is not met as evidenced by: entation review and interview, to test and maintain the Fire accordance with NFPA 70, Code, and NFPA 72, National gnaling Code. The deficient ect 29 out of 29 residents.			1. Maintenance staff will test the DA system after each fire drill. If the fire was not tested during a fire drill ther next day (8am-5pm)the DACT system tested by tripping the fire alarm a contacting the monitoring company 9.7.5, 9.7.7, 9.7.8, and NFPA 25.	e alarm n the em will and	
	A fire alarm syste accordance with a with the requirem Electric Code, and	n - Testing and Maintenance m is tested and maintained in an approved program complying ents of NFPA 70, National d NFPA 72, National Fire Alarm de. Records of system			Completion date 11/02/2016. Correction responsibility and mor to prevent a reoccurrence of the deficiency will be by the Facility	nitoring	

Facility ID: 00982

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION (D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245552	B. WING			11/0	2/2016
	PROVIDER OR SUPPLIER	TON	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 345	K 345 Continued From page 6 acceptance, maintenance and testing available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. Findings include:		K3	345	Maintenance Director, Douglas Hall supervised by Executive Director, C Ness.	as harles	
K 246	on 11/02/2016, doc that the DACT Sys during the 2016 fire shift. This deficient prac Maintenance Direct		L.	346			12/9/16
services for more that period, the authority notified, and the build approved fire watch approved fire alarm system hat 9.6.1.6 This STANDARD is Based on document the Facility failed to paccurate Fire Alarm		Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall be uilding shall be evacuated or an h shall be provided for all ected by the shutdown until the has been returned to service. is not met as evidenced by: entation review and interview, o provide a current and m Out of Service Policy. The	K	345	Correct and update the "Fire Ala Out of Service" policy and insert it is company policy hand book.		12/9/10
	residents. Fire Alarm - Out of Where required fir services for more period, the authori notified, and the brapproved fire water	Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall be uilding shall be evacuated or an this shall be provided for all ected by the shutdown until the			2. Completion date 12/9/2016. 3. Correction responsibility and more to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall supervised by Executive Director, Oness.	ll as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION (X3) DATE COMP	SURVEY PLETED	
		245552	B. WING			/02/2016	
	PROVIDER OR SUPPLIER	TON		н	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 14 EAST PO BOX 219 ALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 346	9.6.1.6 Findings include: On facility tour betwon 11/02/2016, document the Out of Service.	age 7 has been returned to service. ween 10:00 AM and 2:00 PM cumentation review revealed vice Policy for the Fire Alarm ave current staff contact	K	346			
K 354 SS=F	Maintenance Direct NFPA 101 Sprinkle Sprinkler System - Where the sprinkle	r System - Out of Service	K	354		12/9/16	
	determined, areas inspected and risks recommendations or designated repridepartment and ot jurisdiction have be sprinkler system is hours in a 24-hour of the building affe approved fire watc system has been r 18.3.5.1, 19.3.5.1, This STANDARD Based on docume the Facility failed to accurate Fire Sprir	or buildings involved are are determined, are submitted to management esentative, and the fire her authorities having een notified. Where the out of service for more than 10 period, the building or portion cted are evacuated or an h is provided until the sprinkler			Correct and update the "Sprinkler System - Out of Service" policy and insert it into company policy hand book. Completion date 12/9/2016.		
		Out of Service er system is impaired, the n of the impairment has been			Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245552	B. WING		11/0	2/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 354	inspected and risks recommendations or designated repridepartment and of jurisdiction have be sprinkler system is 10 hours in a 24-hiportion of the build an approved fire wis sprinkler system has 3.5.1, 19.3.5.1, Findings include: On facility tour betton 11/02/2016, docton 11/0	or buildings involved are so are determined, are submitted to management esentative, and the fire her authorities having een notified. Where the cout of service for more than our period, the building or ling affected are evacuated or ratch is provided until the as been returned to service. 9.7.5, 15.5.2 (NFPA 25) ween 10:00 AM and 2:00 PM cumentation review revealed vice Policy for the Fire does not have current staff in and the 10 hour out of service updated.	КЗ	Maintenance Director, Doug supervised by Executive Director, Ness.	las Hall as ector, Charles	
K 372 SS=F	Smoke Barrie Subdivision of Buil Construction 2012 EXISTING Smoke barriers sh fire resistance ratii be permitted to ter Smoke dampers a penetrations in full an approved sprin smoke compartme barrier. 19.3.7.3, 8.6.7.1(1	sion of Building Spaces - Iding Spaces - Smoke Barrier Iding Spaces - Smoke Barrier In all be constructed to a 1/2-hour Ing per 8.5. Smoke barriers shall Iminate at an atrium wall. In are not required in duct In y ducted HVAC systems where It will be system is installed for It is ents adjacent to the smoke In anical smoke control system		372		12/25/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED
		245552	B. WING _		11/02/2016	
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP COL HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
K 372	Based on observa facility failed to mal construction that m 101 - 2012 edition, (1). This deficient residents by allowing one smoke compa Subdivision of Build Construction 2012 EXISTING Smoke barriers shall be permitted Smoke dampers a penetrations in full an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1)	is not met as evidenced by: tion and staff interview, the intain smoke barrier walls neet the requirements of NFPA Sections 19-3.7.3 and 8.6.7.1, practice could affect 29 of 29 ng smoke to propagate from rtment to another. ding Spaces - Smoke Barrier all be constructed to a 1/2-hour ng per 8.5. Smoke barriers to terminate at an atrium wall, re not required in duct y ducted HVAC systems where kler system is installed for ents adjacent to the smoke	K 37:	1. Maintenance staff will mak appropriate repairs (fire caulk the penetrations above the la around conduit pipes and spr in the smoke barrier wall at the and 200 Wing Smoke Barrier accordance with 19.3.7.3, 8.6. 2. Completion date 12/25/201 3. Correction responsibility ar to prevent a reoccurrence of deficiency will be by the Facil Maintenance Director, Dougla supervised by Executive Dire Ness.	ing)to seal y-in ceiling inkler pipes ie 100 Wing s.7.1(1) 6. d monitoring the ity as Hall as	
	On facility tour betton 11/02/2016, obsabove the lay-in cesprinkler pipes in the	ween 10:00 AM and 2:00 PM servation revealed penetrations illing around conduit pipes and he smoke barrier wall at the Wing Smoke Barriers.				
K 712 SS=F	Facility Maintenand NFPA 101 Fire Drill Fire Drills Fire drills include t		K 71	2		11/2/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
	PROVIDER OR SUPPLIER		B, WING	S'	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	11/0	2/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 712	times under varyin on each shift. The and is aware that or routine. Responsition conducting drills is persons who are of Where drills are conducted of audible 18.7.1.4 through 19.7.1.7 This STANDARD Based on docume the Facility failed the accordnance with 19.7.1.4 through 1 could affect 29 of 2 fire Drills Fire drills include the signal and simulate conditions. Fire drills include the signal and simulate conditions. Fire drills include the signal and simulate conducting. Responsition on each shift. The and is aware that routine. Responsition conducting drills is persons who are conducting drills are conductin	Ils are held at unexpected g conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. 8.7.1.7, 19.7.1.4 through is not met as evidenced by: entation review and interview, or conduct Fire Drills in 18.7.1.4 through 18.7.1.7, 19.7.1.7. This deficient practice 29 residents the transmission of a fire alarm ion of emergency fire ills are held at unexpected and conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used		712	1. Maintenance staff will conduct once per shift per quarter for all st varying times and conditions as reby NFPA 101 Fire Drills, Section 1 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. 2. Completion date 11/2/2016. 3. Correction responsibility and m to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas H supervised by Executive Director, Ness.	taff at equired 8.7.1.4 onitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245552	B. WING			11/02/2016	
	PROVIDER OR SUPPLIER	TON		нк	REET ADDRESS, CITY, STATE, ZIP CODE GHWAY 14 EAST PO BOX 219 ALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TIVE ACTION SHOULD BE COMPL CED TO THE APPROPRIATE	
		3rd quarter (Jul-Sep) 2016. cice was verified by the Facility tor.	K 7				11/30/16
SS=F	Smoking Regulation Smoking regulation include not less that (1) Smoking shall be ward, or compartme combustible gases and in any other hat area shall be posted SMOKING or shall international symbol (2) In health care of prohibited and sign major entrances, so that prohibits smok (3) Smoking by paresponsible shall be (4) The requirement where the patient in (5) Ashtrays of nor design shall be prosmoking is permitted (6) Metal contained devices into which be readily available permitted. 18.7.4, 19.7.4 This STANDARD Based on document the Facility failed to the standard the facility failed to the standard the facility failed to the standard the stan	ans shall be adopted and shall an the following provisions: be prohibited in any room, ent where flammable liquids, or oxygen is used or stored azardous location, and such ad with signs that read NO be posted with the old for no smoking. In provided at all econdary signs with language sing shall not be required. It et al. (3) shall not apply sunder direct supervision. In combustible material and safe ovided in all areas where ed. It is with self-closing cover ashtrays can be emptied shall at to all areas where smoking is it is not met as evidenced by: entation review and interview, or provide a written current its deficient practice could idents.			New updated "Smoking" policy to Colonial Manor of Balaton to be inserted into the company policy 2. Completion date 11/30/2016.	е	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - Main Building 01	COMPLETED	
		245552	B. WING			11/0	2/2016
	PROVIDER OR SUPPLIER			Н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 14 EAST PO BOX 219 ALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 741	include not less the (1) Smoking shall ward, or comparting combustible gase and in any other harea shall be post SMOKING or sha international symbol (2) In health care prohibited and sig major entrances, that prohibits smo (3) Smoking by paresponsible shall (4) The requirement (5) Ashtrays of no design shall be promotion of the patient (6) Metal contained devices into which	ans shall be adopted and shall can the following provisions: be prohibited in any room, ment where flammable liquids, s, or oxygen is used or stored cazardous location, and such led with signs that read NO ll be posted with the col for no smoking. Occupancies where smoking is ans are prominently placed at all secondary signs with language cking shall not be required. Catients classified as not be prohibited. Cent of 18.7.4(3) shall not apply is under direct supervision.	K 7	741	3. Correction responsibility and moto prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hasupervised by Executive Director, Ness.	all as	
	on 11/02/2016, do	tween 10:00 AM and 2:00 PM ocumentation reviewed revealed oes not have a Written Smoking cific to Colonial Manor of					
K 781 SS=F	Maintenance Dire NFPA 101 Portab Portable Space H	le Space Heaters	K	781			11/30/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG 01 - Main Building 01		SURVEY PLETED
		245552	B. WING _		11/0	2/2016
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CO HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 781	prohibited in all hea unless used in non areas where the he 212 degrees Fahre 18.7.8, 19.7.8 This STANDARD is Based on docume the Facility failed to Space Heater Polic affect 29 of 29 resi Portable Space Hea Portable space hea prohibited in all hea unless used in non areas where the he 212 degrees Fahre 18.7.8, 19.7.8	alth care occupancies, except, sleeping staff and employee eating elements do not exceed enheit (100 degrees Celsius). It is not met as evidenced by: entation review and interview, o provide a written and current cy. This deficient practice could dents.	K 78	1. New updated "Space Heaspecific to Colonial Manor of inserted into the company poly. 2. Completion date 11/30/20 3. Correction responsibility at to prevent a reoccurrence of deficiency will be by the Fact Maintenance Director, Doug supervised by Executive Dir Ness.	f Balaton to be olicy book. 116. and monitoring f the illity las Hall as	
	on 11/02/2016, doc that the Facility doc Heater Policy that Balaton. This deficient prace Maintenance Direct NFPA 101 Electrical Syste Electrical Systems Maintenance and The generator or co and associated eq service within 10 s criterion is not met process shall be process.	al Systems - Essential Electric - Essential Electric System	K 9	18		11/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		COMPLETED	
		245552	B. WING		11/0	2/2016	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
K 918	transfer switches with NFPA 110. Generator sets ar under load 30 mir day intervals, and months for 4 contunder load condit simulated cold statransfer of all EES competent persor stored energy por accordance with licircuit breakers a program for period components is estimated and readily available. circuits are marked Minimizing the post emergency power consideration for 6.4.4, 6.5.4, 6.6.4 111, 700.10 (NFP This STANDARD Based on document of the Facility failed records of Generare maintained and deficient practice electrical System Maintenance and The generator or and associated eservice within 10 criterion is not maprocess shall be	testing of the generator and are performed in accordance be inspected weekly, exercised and the state of the	K 9	1. Maintenance staff will documenting the transfer it takes the emergency goassume power in accordatio. 2. Completion date 11/2/2 3. Correction responsibility to prevent a reoccurrence deficiency will be by the Family Maintenance Director, Dosupervised by Executive Ness.	time of how long enerator to ance with NFPA 2016. Ity and monitoring of the facility buglas Hall as		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245552	B. WING	B. WING		11/02/2016	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR OF BALATON			8 5	н	TREET ADDRESS, CITY, STATE, ZIP CODE IGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 918	Maintenance and to transfer switches a with NFPA 110. Generator sets are under load 30 minuted and intervals, and emonths for 4 continuated cold start transfer of all EES competent persons stored energy power accordance with Nicircuit breakers are program for period components is estamanufacturer requimaintenance and to treadily available. Ecircuits are marked Minimizing the posemergency power consideration for no 6.4.4, 6.5.4, 6.6.4 (111, 700.10 (NFPA). Findings include: On facility tour betwon 11/02/2016, door that not all the required documented during Generator Load Tellong it takes the enpower is not being	esting of the generator and re performed in accordance inspected weekly, exercised ates 12 times a year in 20-40 exercised once every 36 auous hours. Scheduled test and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a loally exercising the ablished according to irements. Written records of esting are maintained and EES electrical panels and and readily identifiable. sibility of damage of the source is a design ew installations. NFPA 99), NFPA 110, NFPA 70) Ween 10:00 AM and 2:00 PM cumentation reviewed revealed aired information is being the Month Emergency generator to assume recorded.	K	918			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted November 18, 2016

Mr. Charles Ness, Administrator Colonial Manor Of Balaton Highway 14 East Po Box 219 Balaton, MN 56115

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5552028 and H5552012

Dear Mr. Ness:

The above facility was surveyed on October 31, 2016 through November 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H55520125. The complaint was found to be substantiated at MN Rules - MN Rule 4658.0405 Subp. 3, MN Rule 4658.0510 Subp. 1, MN Rule 4658.0520 Subp. 2D, MN Rule 4658.0520 Subp.2F., MN Rule 4658.0525 subp 5 A. B., MN Statute 144.651 Subd. 5 and MN Statute 144.651 Subd. 18. 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 <u>only a suggestion</u> 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.

Colonial Manor Of Balaton November 18, 2016 Page 2

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 Kathryn Serie at (507) 476-4233 or email: kathryn.serie@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00982		B. WING		11/0) 3/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 11/0	0,2010
COLONI	AL MANOR OF BALA	ΓΩN	′ 14 EAST P(I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Departments of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated during the deficiency of the survey of t	nether a violation has been				
	that may result from orders provided that the Department with notice of assessme INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Department of the Minnesota Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/30/16 **Electronically Signed**

STATE FORM 6899 1RJI11 If continuation sheet 1 of 50

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00000				11/0	
		00982			11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S 14 EAST PO	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
2 000	Department of Hearyou electronically, is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to emplete the following correction that you and identify the date of the following correction that you and identify the date of the following correction that you and identify the date of the following correction that you and identify the date of the following correction that you and identify the date of the following correction for the following correction that you and identify the date of the following correction orders with the following the	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 4/21/16, surveyors of this visited the above provider and ation orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. Int investigation(s) were also one of the licensing survey. Complaints #H5552012 was implaint was substantiated. Were issued at State Licensing Subp. 3 OSubp. 1 OSubp. 2D OSubp.2F. Subp 5 A. B. 1 Subd. 5	2 000			
		umber appears in the far left Prefix Tag." The state				

Minnesota Department of Health

STATE FORM 6899 1RJI11 If continuation sheet 2 of 50

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		00982	B. WING			3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONIA	AL MANOR OF BALA	LON	′ 14 EAST P(I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 255	"Summary Statement and replaces the "Tourrection order. The findings which are after the statement evidence by." Follo are the Suggested Time period for Complete Plane period	compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute of This Rule is not met as wing the surveyors findings Method of Correction and rection. ARD THE HEADING OF THE NUHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES. O Quality Assessment and the end of the committee consisting of the nursing home's staff, lines director or other physician medical director, and at least ers of the nursing home's staff, lines directly involved in quality assessment and the end of the must identify issues with the properties of the committee must identified. The committee must num, incident and accident control, and medications and	2 000			12/13/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
						;
		00982	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	′ 14 EAST P(I, MN 56115			
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2 255	Continued From pa	ge 3	2 255			
	by: Based on observati review the facility fa assessment and as that responded to ic and failed to implen these concerns so This practice had th residents who resid Findings include:	·		Corrected		
	there was noted to response times and	s from 10/31/16 to 11/2/16 be concerns with call light I lack of cares performed sed needs and cares identified				
	who frequently attermeetings, R7 stated listen to concerns be they review it at the ever happens, like it	th R7 on 11/1/16, at 4:17 p.m., nded the Resident Council d, "They (facility staff) seem to brought up, write it down, and following meeting. Nothing no real follow thru. They just a say they are going but they				
	social worker (SW) council meetings ar minutes/discussion department manage council minutes and department manage and/or widespread	s. She explained that all ers receive a copy of the d it is the responsibility of each er to follow up with specific resident concerns. The SW call light response time has				

Minnesota Department of Health STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		00982	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	14 EAST PO , MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 255	Continued From pa	ge 4	2 255			
	When interviewed of director of nursing (copy of the resident aware of the concerelated to poor call DON indicated only manager attended confirmed she had updates to the cour to call light responsi	on 11/3/16, at 11:43 a.m. the (DON) stated she receives a tocuncil minutes and was rns that residents expressed light response by staff. The the SW and the dietary council meetings and not communicated any notil with their concerns related to the state of the state				
	reviewed for the pre revealed continuou related to slow call documentation: -11/18/15- waiting a -1/12/16- concerns a.m. and p.m2/11/16- call lights waiting a long time -3/23/16- call lights a timely manner5/24/16- some res to an hour to have the -6/22/16- call lights be answered7/13/16- call lights a timely manner10/5/16- call lights time; some stated the No review of previous follow-up regarding	cil meeting minutes were evious 12 months and son-going resident complaints light response as noted in the along time for call lights. For waiting for call lights during not answered very quickly and in the evening, are still not being answered in idents have to wait 45 minutes their call lights answered, are still taking a long time to are still not being answered in continue to have a long wait hey wait 45 minutes or more, us months minutes nor call light concerns noted in minutes reviewed since				
	July 2016 it was no related to the poor	e QAA meeting minutes from ted there was no discussion call light response times and any evidence of concerns				

Minnesota Department of Health

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AND DIAN OF CODDECTION TO THE TOTAL NUMBER.		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		00982	B. WING		11/0	3/2016
NAME OF PROVI	DER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
COLONIAL M	ANOR OF BALA	ΓΟΝ	14 EAST PO , MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
resi facil an a imp ider the to d con resi that add and	lity was aware of action plan had a selemented to trace the concern at the televelop an action acerns and/or evidents. The QA/d an effective play an effective play is the ongoing of the concerns and/or evidents. The QA/d an effective play is the ongoing of the concerns and the	required cares. Although the f ongoing staffing concerns, not been developed nor ck and/or trend the concerns ats. The facility was aware of ime of the meeting and failed a plan to resolve the identified aluate the care provided to A committee lacked evidence in had been developed to g concerns related to staffing and needs.	2 255			
facilia planes	lity could assess an to address the ponse, lack of formely toileting, lack and lack of colits could be perdequate care. The et with nursing solution which involving which involvif.	s resident needs and development lack of timely call light ollowing the plan of care, lack ack of providing grooming consistent staffing levels. If the director of nursing could taff to address the concerns an for sustained problem ared the entire nursing home				
2 555 MN Plar S mus eac com	Rule 4658.0405 n of Care; Devel Subpart 1. Deve st develop a con th resident withir	Subp. 1 Comprehensive opment lopment. A nursing home opprehensive plan of care for a seven days after the omprehensive resident ned in part 4658.0400. The	2 555			12/13/16

Minnesota Department of Health

STATE FORM 6899 1RJI11 If continuation sheet 6 of 50

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. B	BUILDING:	(X3) DATE SURVEY COMPLETED	
00982 B. W	WING	C 11/03/2016	
	SS, CITY, STATE, ZIP CODE EAST PO BOX 219 N 56115		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to the use of oxygen for 1 of 1 resident (R2) reviewed who required oxygen. Findings include: R2's quarterly Minimum Data Set (MDS) dated 9/1/16, reflected R2 used oxygen and was short of breath when sitting and laying flat. Review of the signed physician orders dated 10/19/16, included an order for oxygen 2.0 liter/minute at bedside daily at night. R2's care plan last reviewed 9/9/16, lacked an individualized comprehensive care plan for managing oxygen use. During observation on 11/2/16, at 7:36 a.m. R2 was sleeping in bed with oxygen on at 2.0 liter/minute. During interview on 11/2/16, at 11:17 a.m. R2 stated she uses oxygen at night otherwise she gets short of breath (SOB) when lying in bed, indicating she had been using oxygen this way for almost 2 years.	Corrected		

Minnesota Department of Health

STATE FORM 6899 1RJI11 If continuation sheet 7 of 50

STATEMEN	ND DLAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		00982			11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S 1 14 EAST P(STATE, ZIP CODE		
COLONIA	AL MANOR OF BALA	TON	I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 7	2 555			
	registered nurse (R care plan related to stating, "its been man oxygen depended identified on the plate of nursing (DON) stating interview on of nursing (DON) stating interview on other plate of the p	11/3/16, at 10:34 a.m. director tated her expectation is that a				
	an individualized co include measurable	for Care sive revised 10/2010, indicates omprehensive care plan would e objectives and timetables to medical, nursing, mental and				
	The director of nurs review and revise p to ensuring the care resident is fully devicomprehensive assuring or designed educate staff and densure staff developments.	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related to plan for each individual reloped after the sessment. The director of the could develop a system to levelop a monitoring system to p a comprehensive care plan brehensive assessments.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			12/13/16
		omprehensive plan of care I personnel involved in the t.				

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
			P. MINO				
		00982	B. WING		11/0	3/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
COLONI	AL MANOR OF BALA	I ()N	14 EAST PO I, MN 56115				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 8	2 565				
	by: Based on observatireview the facility far as directed by the control (R3, R5, R6, R20, Findings include: The quarterly Minimassessment dated extensive assistant plan, last revised for identified R3 had a and bathing related care plan further ideand impaired cognitistaff assist for bathing initial observation, at 11:33 and long facial hair on his facial hair was conversation. During observation was seated in the his morning; however present. When interest observation, R3 staface, was unaware indicated she would	num Data Set (MDS) 9/8/16, identified R3 required se with grooming. R3's care r grooming, on 6/24/16 self care deficit with grooming to dementia and arthritis. The sentified R3 had memory loss tion and was dependent upon		Corrected			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
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	00982	B. WING		11/0	3/2016
NAME OF PROVIDER OR SUPPLIE	R STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
COLONIAL MANOR OF BA	ATON	Y 14 EAST PO N, MN 56115			
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
at 7:27 a.m. she hair nor perform she frequently no hair while providid During interview assistant (NA)-D provide facial haresident baths. It is assigned. NA-D have her facial hardening. At 9:38 it was verified R3 removal/grooming confirmed she have provided the R6's annual MD3 identified R6 requith all activities identified R6 free R6's care plan residentified R6 with related to the use plan identified stabrushing his denown teeth. During initial obs 10:39 a.m. R6 whis lower gum lind During observation it was noted that the lower gum are sidentified gum are sidentified stabrushing his denown teeth.	with the hair dresser on 11/2/16, stated she did not remove facial fingernail grooming. She stated stices resident's with long facial ng hair care at the facility. on 11/2/16, at 9:33 a.m. nursing stated staff were expected to r grooming and nail care during NA-D stated she had not given morning but that NA-F had been verified she noted that R3 did not air removed/shaved that a.m. during interview with NA-F had not received facial hair g during the bath. NA-F and not shaved R3 but should be grooming as expected. Sassessment dated 9/8/16, uired extensive assist of two staff of daily living (ADL's) and also of any oral or dental concerns. Vised care plan dated 9/21/16, an alteration in dental status of upper dentures. The care aff would provide oral hygiene by ture and cueing him to brush his ervation of R6 on 10/31/16, at as noted to have natural teeth one that were missing and broken. On of R6 on 11/1/16 at 4:35 p.m. multiple teeth were somewhat he oral cavity. There was				

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STATE FORM 6899 1RJI11 If continuation sheet 10 of 50

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00982	B. WING		11/0	; 3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
COLONI	AL MANOR OF BALA	TON	14 EAST PO			
	ı	BALATON	I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
		ums R6's lower natural teeth acked , discolored and had ris.				
	R6 stated staff were cares but they forgo	th R6 on 11/2/16 at 8:11 a.m. e supposed to do his oral ot sometimes. R6 stated staff his dental cares last evening norning (11/2/16).				
	identified R20 requistaff with toileting. identified R20 with a incontinence related from dementia, psy immobility. The care	ange MDS dated 8/12/16 fred extensive assist of two R20's care plan dated 8/18/16, an alteration in bladder d to functional impairment chotropic drug use, pain and e plan identified R20 had a to be toileted every two hours.				
	2:20 p.m. R20 was her room between h was noted to be a p the middle of room. observation, traine (TMA)-A was made entered R20's room	vation of R20 on 10/31/16, at seated in her wheelchair in her bathroom and room. There buddle of urine on the floor in At the time of the d medication assistant aware of the observation and in to assist R20. TMA stated t on staff and mechanical lift				
	a.m. R20 was obse	of cares on 11/2/16, at 6:45 rved seated in hallway by er wheelchair with eyes closed.				
	at 6:58 a.m. R20 was seated in hallway by R20 was assisted of	of morning cares on 11/2/16, as observed seated in the y nurses station. NA-B stated out of bed at approximately time she was toileted.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00982	B. WING		11/0) 3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	Y 14 EAST PO N, MN 56115			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 565	Continued From pa	ge 11	2 565			
		a.m. R20 was wheeled into aced seated at table in her				
	On 11/2/16, at 9:02 the dining room at t	a.m. R20 remained seated in able.				
		a.m. R20 remained in dining erved slowly wheeling herself or.				
	out of dining room a	4 a.m. R20 wheeled herself and into hallway by nurses I her hands and feet to propel				
		a.m. R20 was seated in her at newspaper while seated in e station.				
	the bathroom at the hairdresser was wa stated staff needed was fixed. R20 was minutes after her as gotten up. After toile	S a.m. NA-D assisted R20 to a nurses station as the iting to do R20's hair and to toilet R20 before her hair toileted 3 hours and 30 ssistance with toileting when eting NA-D stated R20 was en toileted and in addition, toileted.				
	and again on 11/2/ fingernails were obs	s on 10/31/16, at 11:10 a.m., 16, at 1:14 p.m. R5's served to be long, jagged with ne nail on both hands.				
		nulative Diagnosis List dated diagnosis of diabetes mellitus.				
		rterly Minimum Data Set dated 9/19/16, indicated R5				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00982	B. WING			3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	LON	' 14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	nge 12	2 565			
	had a Brief Intervie	w for Mental Status (BIMS) g severe cognitive impairment sive assistance of one staff				
	R5 with a functiona	e plan dated 9/16, identified Il deficit in personal hygiene assistance with bathing and				
	indicated R5's nail days as R5 require included R5 had dia was only provided I follow-up interview	on 11/2/16, at 7:15 a.m. NA-B care is completed on bath d assistance. NA-B further abetes and therefore nail care by the licensed nurses. A with LPN-B on 11/2/16, at 7:33 s nail care is performed staff/nurse.				
	2016, included a nu fingernails weekly o mornings). Review indicated nail care	atment record dated October cursing order to trim R5's on bath days (Monday of the documentation had been completed on nails continued to be long, a debris on 11/2/16.				
	1:17 p.m. with NA-	nd observation on 11/2/16, at B, it was confirmed R5's ng, jagged and had dark debris				
	DON indicated she	11/3/16, at 11:40 a.m. the would have expected R5's by the licensed nurse per as needed.				
	11/1/16, at 1:49 p.n	ew and observation of R14 on n. R14 was noted to have with sharply cut angles. R14				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		С	
		00982	B. WING	· · · · · · · · · · · · · · · · · · ·		3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
	indicated she did no	them in a hurry". R14 ot like how they were trimmed. Dished but heavily worn.				
		on 11/2/15, at 6:59 a.m. R14's ged with sharply cut angles.				
		11/2/16, at 7:15 a.m. NA-B gernails should be cleaned th days.				
	indicated R14 had a severe cognitive im	mission MDS dated 8/9/16, a BIMS score of 4 indicating pairment and requiring ce of 1 staff with personal				
	Review of R14's care plan dated 9/21/16, directed NA to do nail care weekly on bath days (Friday morning) and requires extensive assistance of 1 staff with grooming.					
		ath Report dated 10/28/16, did or the residents fingernails had				
	DON indicated she fingernails to be trir	11/3/16, at 11:40 a.m. the would have expected R14's nmed per resident's liking on eeded as directed on the plan				
	nail care includes d trimming. It directs and under each nai	s revised 10/2010, indicates aily cleaning and regular to remove dirt from around I with an orange stick, trim al shape, and to smooth the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00982	B. WING		11/0) 3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
COLONI	AL MANOR OF BALA	TON HIGHWAY	/ 14 EAST PO	D BOX 219		
0020111		BALATOI	N, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 14	2 565			
	severe cognitive im required total assist	dated 8/25/16, indicated pairment per staff interview, tance of two staff for transfers ontinent of bowel and bladder.				
	instructed nursing to urinary incontinence	e plan updated 8/27/16, o check and change for e every 2 hours and transfer byer (mechanical device used				
	states R9 gets up o lift (a mechanical st but after that is tran	11/1/16, at 5:35 p.m. NA-A on a commode using a stand anding device) before supper sferred using a Hoyer lift and heck and change of				
	stated R9 is placed	11/2/16, at 1:30 p.m. NA-F on a commode after Stand lift and two assist.				
		11/2/16, at 1:39 p.m. NA-B sted on commode with a Stand				
	stated R9 transfers commode before a stated a Stand lift h cares and R9 had b prior to the breakfas	11/3/16, at 8:17 a.m. NA-I with a Stand lift to the nd after every meal. NA-I ad been utilized with morning been assisted to the commode at meal. NA-I then verified this is restorative charting record				
	stated R9 is to be to is checked and cha incontinence care.	11/3/16, at 10:50 a.m. RN-B ransferred with a Hoyer lift and nged every 2 hours for RN-B verified this change had 5 per the care plan as sitting				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.12 . 27.1.1	o. oo20		A. BUILDING:			
		00982	B. WING		11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLONIA	AL MANOR OF BALA	ION	14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	confirmed the staff charting record did information commuplan and NA's were related to transfers When interviewed of DON verified staff in had not been follow directed. The DON the restorative sheet to be accurate per little	I been upsetting for R9. RN-B care list and restorative not have the correct nicated from the current care not following care plan and toileting. In 11/3/16, at 11:15 a.m. the nad incorrect information and ring the plan of care as confirmed she would expect and care lists used by NA's R9's care plan. If or Care sive revised 10/2010, indicates ons are designed after careful areas and their causes. Sidents are ongoing and care information about the nt's condition change. IHOD OF CORRECTION: The signee could develop a system of develop a monitoring system providing care as directed by care. Care plans could be they are accurate and	2 565			
2 800	(21) days. MN Rule 4658.0510 Staffing requirement	O Subp. 1 Nursing Personnel; nts	2 800			12/13/16
		requirements. A nursing n duty at all times a sufficient				

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00982			11/0	; 3/2016
NAME OF I					11/0	3/2010
	PROVIDER OR SUPPLIER	HIGHWAY	14 EAST PO	STATE, ZIP CODE D BOX 219		
COLONI	AL MANOR OF BALA	TON	, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 16	2 800			
	registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	nursing personnel, including icensed practical nurses, and o meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, sements.				
	by: Based on observatifailed to ensure suffered resident need grooming, oral care light response for 8 R6,R9, R14, R20, F	on and interview the facility ficient staffing was available to s related to appropriate of 29 residents (R3, R5, R29, R31). This had the II 29 residents in the facility.		Corrected		
	Findings include:					
	review the facility facall light requests a manner for 3 of 3 re	on, interview and document tiled to promptly respond to nd/or speak in a respectful esidents (R6, R31, R29) who ot provide dignified care.				
	facility failed to com related to the ongoi light response time group over the past	t review and interview the imunicate actions taken ng complaints of delayed call expressed by the resident 12 months. This has the 129 residents who reside in 5 F244.				
	review the facility fa as directed by the o	on, interview and document tiled to provide personal cares tare plan for 6 of 10 residents R14, R9) reviewed. Refer to				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPI	
					C	
		00982	b. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	14 EAST PO I, MN 56115	D BOX 219		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NC N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	COMPLETE DATE
2 800	Continued From pa	ge 17	2 800			
	F282.					
	review the facility fa for 5 of 10 residents reviewed who were	ion, interview and document ailed to provide grooming cares is (R3, R6, R20, R5, R14) unable to perform grooming ne without extensive staff to F312.				
	review the facility fa services for 2 of 2 r	ion, interview and document ailed to provide timely toileting residents (R20, R31) reviewed assistance with toileting needs.				
	Additional Interview	rs:				
	nursing assistant (NNAs working from 2 provide care for 29 arrived to assist. T 2 NAs working can depending on the dwilling to come in.	on 11/1/16, at 5:26 p.m. NA)-I -stated there are only 2 2:00 p.m. until 4:00 p.m. to residents until a 3rd NA he time frame for only having vary from 2-8 hours ay and whether anyone is NA-I indicated there is always it does take awhile to get to				
	indicated at times to or working short. Note is normally 4 NAs a example, this morn assistant on duty- 1 persons on the 200 was according to the "there is not enough and indicated short weekly. NA-C confidence."	on 11/2/16, at 10:14 a.m. NA-C he facility is "staff challenged" IA-C indicated the aide staffing and 1 restorative NA; for ing there were only 3 nursing person on the 100 wing and 2 wing. NA-C indicated this he schedule. NA-C stated, h staff for all the shifts here" staffing occurs at least 2 x irmed there were times that ry/incontinent episodes as a				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 18 STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETE DATE OF COMPLETE DATE OF COMPLETE DATE OF CONTINUED TO THE APPROPRIATE DATE OF CONTINUED TO THE AP	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE S	
COLONIAL MANOR OF BALATON HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)		00982	00982	B. WING	·····		
COLONIAL MANOR OF BALATON BALATON, MN 56115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	NAME OF PROVIDER OR SUPPLIE	R STREET AD	ER OR SUPPLIER STREE	DRESS, CITY,	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETICATION) TAG DEFICIENCY)	COLONIAL MANOR OF BAL	ATON	NOR OF BALATON	_			
2 800 Continued From page 18 2 800	PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
result of staff not being able to "get to them". During an interview on 11/3/16, at 8:32 a.m. NA-J (restorative) indicated a restorative program had been developed and provided a list detailing the programs provided for each resident. NA-J confirmed that although he was scheduled as the restorative nursing role, he would be re-assigned to the floor to help if there was a staff shortage. NA-J indicated this occurred a couple of times/pay period. NA-J indicated this interferes with consistently implementing each resident's restorative program. NA-J indicated the interferes with consistently implementing each resident's restorative duties assignment normally filled an 8 hour shift with minimal assistance provided to the other NAs. When interviewed on 11//2/16, at 12:53 p.m. the director of nursing (DON) was questioned about R6's call light response time during the observation on the evening of 11/1/16. The DON stated she felt staff should respond to any resident call light within five minutes. The DON further stated staff should at least stop by and ask the resident what they need and notify them they will return. The DON also stated it was hard for the staff to get all of the work done with just three nurses aides scheduled as it was better with 4 staff. The DON said she had frequent call- ins and has been unable to replace staff as it was difficult to find staff to hire. During a subsequent interview on 11/03/2016, at 8:47 a.m. the DON indicated appropriate response time for acknowledge of a resident's need would be 5 minutes and response within 15 minutes. Review of the policy from Personnel and Staffing indicated The Director of Nursing Services and/or	result of staff not During an intervie (restorative) indice been developed a programs provide confirmed that alterestorative nursing to the floor to help NA-J indicated the times/pay period. With consistently restorative programestorative duties hour shift with mitother NAs. When interviewed director of nursing R6's call light resubservation on the stated she felt staresident call light further stated state the resident what will return. The Enthe staff to get all nurses aides schestaff. The DON stand has been undifficult to find state the polygon of the polygon of the polygon of the polygon. Beview of the polygon of the poly	being able to "get to them". w on 11/3/16, at 8:32 a.m. NA-Jated a restorative program had and provided a list detailing the difference of the would be re-assigned of there was a staff shortage. In soccurred a couple of the work as a staff shortage. In soccurred a couple of the work as a staff shortage. In the work as a staff shortage within five minutes. The DON if should at least stop by and ask they need and notify them they on also stated it was hard for of the work done with just three eduled as it was better with 4 aid she had frequent call- insuble to replace staff as it was if to hire. The work done with just three eduled as it was better with 4 aid she had frequent call- insuble to replace staff as it was if to hire. The work done with just three eduled as it was better with 4 aid she had frequent call- insuble to replace staff as it was if to hire. The work done with just three eduled as it was better with 4 aid she had frequent call- insuble to replace staff as it was if to hire. The work done with just three eduled as it was better with 4 aid she had frequent call- insuble to replace staff as it was if to hire. The work done with just three eduled as it was better with 4 aid she had frequent call- insuble to replace staff as it was if to hire.	It of staff not being able to "get to them". In g an interview on 11/3/16, at 8:32 a.m. No orative) indicated a restorative program had developed and provided a list detailing the rams provided for each resident. NA-Jurned that although he was scheduled as orative nursing role, he would be re-assigned floor to help if there was a staff shortage of indicated this occurred a couple of sopay period. NA-Jurned indicated this interfere consistently implementing each resident's orative program. NA-Jurned the orative duties assignment normally filled any shift with minimal assistance provided to revalue to the control of the provided to the control of the provided to the control of the provided to revalue to the control of the provided to the control of the provided to the control of the provided to the provided to the provided to the control of the provided to the provid				

Minnesota Department of Health

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00000			(
		00982			11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
L COLONIAL MANOR OF BALATON			14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 19	2 800			
	minimum, is respor schedules and staff residents; providing necessary or appro	or/Charge Nurse, as a naible for: Assigning work fing to meet the needs of direct resident care as priate, and other tasks and become necessary.				
	SUGGESTED METHOD OF CORRECTION: Facility administration and the director of nursing could utilize employee, resident and family input to evaluate staffing patterns and identify times/ places where those staffing patterns could/should be adjusted and implement those adjustments in order to meet all resident needs in a timely manner. Facility policies and procedures for sufficient staffing could be reviewed/ revised. Pertinent employees could be re-trained on those policies/ practices. Audit tools could be developed to observe for timely and complete care, meeting all resident needs as identified in their care plan. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			12/13/16
	receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00982	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	ION	14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	of bed as much as written order from t	possible unless there is a he attending physician that the lin in bed or the resident	2 830			
	by: Based on observative review the facility facility facility facility facility facility facility facility facility facility.	ent is not met as evidenced on, interview and document alled to comprehensively r and implement the use of r 1 of 1 resident (R13) who ntly.		Corrected		
	Findings include:					
	included: chronic of disease(COPD), hy pressure), unspecif	et from the electronic record obstructive pulmonary opertension (high blood ied cerebrovascular disease, ular dementia and nicotine				
	assessment dated on the Brief Intervie indicating intact cog	Minimum Data Set (MDS) 9/9/16, indicated a 14 score ew of Mental Status (BIMS) gnition. R13's activities of daily endent with eating and rsonal hygiene.				
	for R13, initially dat quarterly (4/30/15, 7/25/16 and 10/20/ R13 was allowed to areas reviewed by included: (1) able to	king Assessment conducted ed 4/30/15 and subsequent 7/29/15, 10/29/15, 1/25/16, 16) assessments indicated a smoke independently. The the nurse on the assessment o verbalize safety precautions, of ashes/cigarettes safely; (3)				

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STATE FORM 6899 1RJI11 If continuation sheet 21 of 50

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILBING.			
		00982	B. WING			3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	LON	' 14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	hands are steady a cigarette; and (4) a However, none of treview of whether or clothing or personal R13's care plan wit listed a goal: will cosmoking through noincluded: (1.) Nursiquarterly and as necurrently independent Nurses/Nurse Aidemonitor for burn macare lacked any meany other safety ap During observation R13 was seated or East entrance smowearing a multicolog gloves with vinyl or blue fleece blanket this observation R1 multiple burn holes eraser to dime size prevalent on the rigedges of the holes R13 was holding he hand and the vinyl her index finger (befingers) had a melt on R13's lap also covarying sizes. When interviewed confirmed the holes onto her jacket and	and physically able to hold ble to call for assistance. he assessments included or not R13 had burn marks in all belongings. The a revision dated 10/21/16 ontinue to remain safe with her ext review. Interventions reseasses for smoking safety reded (PRN). (2.) Resident is ent - unsupervised; (3.) Monitor for safe smoking, arks in clothing. The plan of rention of a smoking apron nor	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00982	B. WING			C 03/2016
				STATE, ZIP CODE D BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	and 2nd fingers of a greed the vinyl wa not burned herself a cigarette that short. been offered a smocover for her clothin alright. R13 further this jacket and usin "years" and didn't k holes were recent a When interviewed of director of nursing aware of R13's smocent she had been wear the same blanket in The DON verified smarks located on the DON confirmed she smoking apron had available for R13's During interview on licensed practical in seen "a couple" of and not aware of an R13 usually goes of and was able to go independently. During an interview LPN-A indicated she quarterly smoking a was note aware of and/or blanket, LP recent assessment conducted she coul wearing her jacket LPN-A indicated she	ner right gloved hand and s melted, but stated she had and that she didn't smoke her R13 stated she had never oking apron nor protective ng, but thought it would be stated she had been wearing g the same lap blanket for now whether the identified and/or "old" burn areas. on 10/31/16, at 1:05 p.m. the (DON) indicated she was oking habits and confirmed ing the same jacket and using a her wheelchair "for years". he was not aware of the burn he jacket nor the blanket. The e was unaware whether a been offered and/or had been use. 10/31/16, at 2:04 p.m. urse (LPN)-C stated she has ourn holes, but nothing major nything new. LPN-C indicated ut to smoke 2-3 times/dayshift				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00982	B. WING		C 11/03/2016	
					11/0	3/2010
	PROVIDER OR SUPPLIER	HIGHWAY	DRESS, CITY, S 14 EAST PO	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	I, MN 56115	7 BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 23	2 830			
	further stated she had while smoking. LPI Smoking assessme R13 had been assessmoking. However whether she had be personal belongs. never assessed R1 When interviewed on ursing assistant (Naide (TMA)-B both smokes independe aware of any burn riblanket.	and not seen R13 wear gloves N-A provided the Resident ent document which indicated essed for independent, R13 had not been assessed arn marks in clothing or LPN-A confirmed she had 3 related to this issue. In 10/31/16, at 2:17 p.m. NA)-H and trained medication agreed that R13 normally ently and neither staff were marks on R13's jacket or				
	During interview on 10/31/16, at 2:51 p.m. TMA-A indicated R13 often went outside to sit and visit with R13 while she smoked independently. TMA-A also indicated she wasn't aware of R13 dropping ashes on herself nor of the melted areas evident on her glove. When questioned whether R13 had been offered a smoking apron, she replied she was unaware of what a smoking apron was until co-workers informed her.					
	11/2/16, at 11:15 a. been re-evaluated to (after survey entrar smoking assessment should	interview with the DON on m. it was confirmed R13 just for safe smoking on 10/31/16 ice). The DON reviewed the nt and confirmed the complete have included whether there rn marks in clothing/personal re ongoing safety.				
	a.m. the DON confi include intervention	erview on 11/03/16, at 9:16 rmed the care plan did not s related to the use of a sessment of clothing, blanket				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		00982	B. WING		11/0	C 03/2016
	PROVIDER OR SUPPLIER	TON HIGHWAY	DRESS, CITY, 9 7 14 EAST PO 1, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	and/or additional per while smoking for I she would expect the No policy or proceds smoking was provided SUGGESTED MET director of nursing a smoke and ensure assessed as part or independently. An ensure the assessmanter staff has been supervision of smol be reviewed at qual meetings.	ersonal items worn/utilized ourn marks. She confirmed nis to be completed.	2 830			
2 850	Subp. 2. Criteria for proper care. The cadequate and proper D. Assistance of all residents as and well-groomed. This MN Requirements: Based on observation of a content of the facility for a content of the facility	r determining adequate and criteria for determining	2 850	Corrected		12/13/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00982		B. WING			C 03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	/ 14 EAST PC N, MN 56115			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 25	2 850			
	without extensive s	taff assistance.				
	Findings include:					
	assessment dated Brief Interview for N 3, indicating severe	num Data Set (MDS) 9/8/16, identified R3 with a Mental Status (BIMS) score of cognition impairment and equired extensive assistance ng.				
	6/24/16, identified t with grooming and and arthritis and wa assistance with bat	revised for grooming, on hat R3 had a self care deficit bathing related to dementia as dependent upon staff hing and grooming needs. The entified R3 had memory loss tion.				
	11/1/16, at 11:33 a. long facial hair on h	vation in the dining room on m. R3 was observed to have her chin and under her nose. easy to visualize during				
	was seated in the h the nurses station. this morning; howe present. When into observation, R3 sta face, was unaware indicated she would	on 11/2/16, at 6:57 a.m. R3 callway in her wheelchair by R3 stated she had her bath over, visible long facial hair was erviewed at the time of the sted she did not like hair on her she had facial hair but d like the hair shaved. R3 know who was supposed to				
	at 7:27 a.m. she sta hair nor perform fin	th the hair dresser on 11/2/16, ated she did not remove facial gernail grooming. She stated tes resident's with long facial				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		00982	B. WING			3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONIAL MANOR OF RALATON			14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 26	2 850			
	hair while providing	hair care at the facility.				
	assistant (NA)-D st provide facial hair gresident baths. NA R3 her bath this massigned. NA-D ver have her facial hair morning. At 9:38 a it was verified R3 h removal/grooming confirmed she had have provided the ground of the nurses' static long facial hairs on	ated staff were expected to grooming and nail care during are been orning but that NA-F had been orified she noted that R3 did not removed/shaved that and during interview with NA-F and not received facial hair during the bath. NA-F not shaved R3 but should grooming as expected. of cares on 11/1/16, at 4:06 and in her wheelchair adjacent on. R20 was noted to have her chin and sides of face uring interaction with the				
	a.m. R20 was obse	of cares on 11/2/16, at 6:58 erved seated in her wheelchair station and long facial hairs interaction with the resident.				
	at 12:47 p.m. staff v presence of R20's a R20 had a bath the facial hairs should I	with NA-C and NA-F at 11/2/16, were questioned about the facial hair. Both NA's stated morning of 10/31/16 and the nave been hair clipped during confirmed it had not been				
	(DON) on 11/2/16,	th the director of nursing at 2:00 p.m. it was verified a shaving services to all days as needed.				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00982	B. WING			C 03/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
COLONIA	AL MANOR OF BALA	ION	′ 14 EAST P I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 850	revised 10/2010, id policy was to promo clean skin care and 1. Review resident's special needs of the 2. Assemble equipored The policy did not it shave residents or residents, but just it shaving. No other pubmitted by facility SUGGESTED MET director of nursing in-service all staff of living (such as shave director of nursing compliance. TIME PERIOD FOR (21) days.	or "Shaving the Resident", entified the purpose of the ote cleanliness and to provide didentified: so care plan to assess for any eresident. ment and supplies as needed. Include directions for when to how to shave female included basic guidelines for collicy for shaving was of the collicy for shaving was of the collicy for residents. Also the for designee could monitor for the control of the collicy for residents. Also the for designee could monitor for the control of the collicy for the collicy for residents. Also the for designee could monitor for the collicy for the collicy for the collicy for the collicy for residents. Also the for designee could monitor for the collicy fo	2 850			12/12/16
2 860	Subp. 2. Criteria for proper care. The cadequate and proper. per care and att	or determining adequate and riteria for determining	2 860			12/13/16
	by: Based on observati interview the facility	ent is not met as evidenced ion, document review and realled to provide the proper residents (R5, R14) reviewed		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00982	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONIA	COLONIAL MANOR OF BALATON		′ 14 EAST P(I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 28	2 860			
	who were depended	nt upon staff for nail care.				
	Findings include:					
	and again on 11/2/fingernails were obs	on 10/31/16, at 11:10 a.m., 16, at 1:14 p.m. R5's served to be long, jagged with ne nail on both hands.				
	10/12/16, included Review of R5's qua (MDS) assessment had a Brief Interview score of 5 indicating	nulative Diagnosis List dated diagnosis of diabetes mellitus. rterly Minimum Data Set dated 9/19/16, indicated R5 w for Mental Status (BIMS) g severe cognitive impairment sive assistance of one staff nal hygiene.				
	R5 with a functiona	e plan dated 9/16, identified I deficit in personal hygiene assistance with bathing and				
	indicated nail care f days and R5 require included R5 had dia was only provided b Follow-up interview (LPN)-B on 11/2/16	11/2/16, at 7:15 a.m. NA-B for R5 is completed on bath ed assistance. NA-B further abetes and therefore nail care by the licensed nurses. with licensed practical nurse at 7:33 a.m. confirmed R5's eackly by the licensed nurse.				
	2016, included a nu fingernails weekly o mornings). Review indicated nail care h	tment record dated October ursing order to trim R5's on bath days (Monday of the documentation nad been completed on R5's nails remained long and debris on 11/2/16.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00982	B. WING			C 03/2016
	PROVIDER OR SUPPLIER AL MANOR OF BALA	TON HIGHWA	DDRESS, CITY, S Y 14 EAST PO N, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 860	During interview and 1:17 p.m. with NA-were long, jagged a nail. During interview with 11:40 a.m. it was in nails to be trimmed nursing orders and During initial interview 11/1/16, at 1:49 p.m. jagged finger nails stated, "the girl did indicated she did not R14's nails were possible of R14's nails were possible of R14's addinated R14 had a severe cognitive important extensive assistant hygiene needs. Review of R14's can NA to do nail care with morning) and requistaff with grooming.	d observation on 11/2/16, at B, confirmed R5's fingernails and had dark debris under the the the DON on 11/3/16, at dicated she expected R5's by the licensed nurse per as needed. ew and observation of R14 on n. R14 was observed to have with sharply cut angles. R14 them in a hurry". R14 of like how they were trimmed. Olished but heavily worn. on 11/2/15, at 6:59 a.m. R14's ged with sharply cut angles. Imission MDS dated 8/9/16, a BIMS score of 4 indicating pairment and requiring the of 1 staff with personal ore plan dated 9/21/16, directed weekly on bath days (Friday red extensive assistance of 1				
	been trimmed. During interview on indicated R14's fing trimmed on bath da	11/2/16, at 7:15 a.m. NA-B gernails should be cleaned and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 20.123.1.10.1		С	
		00982	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONI	COLONIAL MANOR OF BALATON BALATO			O BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ge 30	2 860			
		would have expected R14's nmed per residents liking on eeded.				
	nail care includes d trimming. It directs and under each nai	s revised 10/2010, indicates aily cleaning and regular to remove dirt from around I with an orange stick, trim al shape, and to smooth the				
	director of nursing of systems to ensure of the assistance need or her designee cou	THOD OF CORRECTION: The or her designee could develop dependent residents receive ded for their cares. The DON ald educate all appropriate designee could develop to ensure ongoing				
	TIME PERIOD FOR one(21) days.	R CORRECTION: Twenty				
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			12/13/16
	have a continuous programment to recommend to recommend to recommend to recommend the comprehensive results and a resident without an indwelling unless the resident that catheterization B. a resident where the continuous programment is a continuous programment to the continuous programment to recommend to the continuous programment to recommend to recommend to the continuous programment to recommend to recommend to the comprehensive resident with the continuous programment to recommend to the comprehensive resident with the continuous programment to the comprehensive resident with the continuous programment to the continuous pro	nce. A nursing home must program of bowel and bladder duce incontinence and the catheters. Based on the ident assessment, a nursing that: ho enters a nursing home g catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00982	B. WING			3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	COLONIAL MANOR OF BALATON HIGHWA BALATO			O BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	prevent urinary trac	ge 31 It infections and to restore as er function as possible.	2 910			
	by: Based on observati review the facility fa services for 2 of 2 r	ent is not met as evidenced on, interview and document alled to provide timely toileting esidents (R20, R31) reviewed assistance with toileting needs.		Corrected		
	Findings include:					
	(MDS) assessment required extensive toileting. The MDS frequently incontine toileting program ar previous toileting pl	ange Minimum Data Set dated 8/12/16, identified R20 assist of two staff with further identified R20 was ent of urine and did not have a and identified there had been a an which demonstrated R20 inence with the implemented				
	from 8/13/16-8/15/1 identify the need to toilet when toileted on some occasions at times of toileting.	ssment (3 day toileting log (6) identified R20 was able to void and was able to void in every two hour. Even though R20 was incontinent of urine (documented-small amount), ish voiding when toileted.				
	an alteration in blac functional impairme psychotropic drug u	use, pain and immobility. The R20 had a toileting schedule				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			С	
		00982	B. WING			3/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COLONIAL MANOR OF RALATON			14 EAST PO I, MN 56115				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 910	During initial observation, trained observation, trained (TMA)-A was made entered R20's room R20 was dependent to transfer to the to odor and incontiner. During observation p.m. R20 was seate station and was not present when stand. During observation p.m. R20 was seate station and was not present when stand. During observation p.m. R20 was assist the nurses station. assisted R20) verificurine when taken in she also noted the was unsure where. During observation a.m. R20 was seate station in her whee 6:58 a.m. R20 remain the same location time, NA-B stated Fapproximately 6:15 time. At 7:32 a.m. dining room and se R20 remained seat same table. At 9:21 by slowly wheeling At 9:24 a.m. R20 vhallway located by a.m. R20 remained seats same table ocated by a.m. R20 remained seats same R20 re	vation of R20 on 10/31/16, at seated in her wheelchair in ddle of urine was noted on the of room. At the time of the d medication assistant aware of the observation and in to assist R20. TMA-A stated in ton staff and a mechanical lift illet. TMA-A verified the urine ince. of cares on 11/1/16, at 4:06 and in the hallway by nurses ted to have a strong urine odor ding nearby. of cares on 11/1/16, at 5:05 ated to the toilet located near Nursing assistant (NA)-A (who ited R20 was incontinent of into the bathroom and stated strong urine odor present but	2 910				

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00982			11/0	; 3/2016
	COLONIAL MANOR OF BALATON HIGHWAY			STATE, ZIP CODE D BOX 219	1 11/0	0/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I, MN 56115 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	hairdresser, who we stated staff needed arrived in the beaut assisted R20 into to nurses station. R20 minutes (6:15 a.m. assisted with morni provided, NA-D corwet when assisted some urine while on When interviewed on ursing assistant (Nability to void in the remained dry when schedule. When interviewed or registered nurse (Ratwo hour toilet schedule) to hour toilet schedule whour toilet schedule for at a minimal minimal management of the province of the pro	as waiting to fix R20's hair, to toilet R20 before she y shop. At 9:46 a.m. NA-D he bathroom located near the 0 was toileted 3 hours and 30 -9:46 a.m.) after she was ng cares. After toileting was offirmed R20 was moderately and also verified R20 voided	2 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00982	B. WING			3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COLONIA	AL MANOR OF BALA	ION	' 14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 34	2 910			
	am incontinent and brief for a long time upset." R31 stated time 2-3 times/weel timeframe's to wait meal times and on When interviewed of	, "I put my call light on when I I have to sit in an incontinent a. That makes me feel awful he had to wait that length of k. R31 indicated the worst for assistance were during weekends. on 11/2/16, at 12:53 p.m. the (DON) about R31's call light				
	response time and	stated if she would have been blaints she would have				
	Continence and Inc Management. The assessments would identify staff's response	d a policy titled Urinary continence- Assessment and policy identified how do be conducted but did not possibility to ensure followed. No other policy was				
	The director of nurs all residents at risk they are receiving the treatment/services incontinence. The I educate all appropri provision of service	to prevent/minimize DON or designee, could iate staff on the appropriate s for incontinence. The DON conduct random audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21325	MN Rule 4658.0729 Emergency Oral He	5 Subp. 1 Providing Routine & ealth Ser	21325			12/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00982	B. WING		11/0) 3/2016
	PROVIDER OR SUPPLIER AL MANOR OF BALA	TON HIGHWAY	DRESS, CITY, S 14 EAST PO 1, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	Subpart 1. Routine home must provide resource, routine de needs of each resicinclude dental exam fillings and crowns, oral surgery, bridge orthodontic proceduthat are provided fo community at large reimbursement poli. This MN Requirement by: Based on observatireview the facility fadental services for who had notable briteeth. Findings include. R6's annual Minimulassessment dated extensive assist of daily living (ADL's). identified a Brief Int (BIMS) score of 12 impairment. The MI delusions or psychominimum indicators MDS identified R6 froncerns. During initial observations a.m. R6 was his lower gum line to broken.	e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services ninations and cleanings, root canals, periodontal care, s and removable dentures, ares, and adjunctive services r similar dental patients in the as limited by third party cies. ent is not met as evidenced on, interview and document alled to offer and provide of 3 residents (R6) reviewed oken and decaying natural	21325	Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00982	B. WING		11/0) 3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	′ 14 EAST PC I, MN 56115	D BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21325	R6 was observed ly It was noted that R6 teeth and in additio protruding from the evidence of dark conthe two front teeth I R6's lower natural to cracked, discolored debris coating ther. On 11/1/16, at 6:22 evening meal in his of soup, banana an R6's top dentures who located on the night. During interview on stated staff were subut they forgot som staff did not comple evening [11/1/16] now when interviewed or registered nurse (Raware of R6's dentabelieved she visual completed the annum 9/8/16. RN-B verifification free of any oral/dentabelieved she visual completed the annum 9/8/16. RN-B verifification of the confirmed R6 had resince January 2015 would desire another the surveyor to When observed, RI of the cracked, broteeth. RN-B stated mouth for her to visual countries when observed is the cracked of the cracked of the cracked of the cracked of the cracked on the results of the cracked on the countries would desire another the cracked on the cracked	ving in bed watching television. So had multiple missing lower in, teeth were somewhat oral cavity. There was allored areas at the gum line of ocated on the lower gums. eeth were noted to be and have excessive food in. p.m. R6 was eating the room and was served a bowled ice cream. It was noted that were stored in a denture cup it stand. 11/2/16, at 8:11 a.m. R6 apposed to do his oral cares etimes. R6 confirmed that ete his dental cares last for this morning. 20 11/2/16, at 1:16 p.m. N)-B stated she was not all concerns and indicated she is it	21325			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		00982	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	ION	′ 14 EAST P0 I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21325	would like have a d dentist. R6 shook have a didentist. R6 shook have have have have have have have have	ental appointment with the nis head "Yes" and responded, my dentist." Examination/Assessment 14, identified each resident ental assessment prior to or dmission. If the offered dental services as lexaminations will be made ersonal dentist or by the dentist. (3.) Records of dental be made part of the resident's Upon conducting dental dent needing dental services erred to a dentist. HOD OF CORRECTION: The could develop a system to dental services are provided pon resident request. Staff on the system to ensure tion with the on-site dental ould be conducted and rterly quality assurance	21325			
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			12/13/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00982	B. WING		11/0) 3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON	Y 14 EAST P			
	I	BALATOI	N, MN 56115	T		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 38	21375			
	This MN Requirements by: Based on observative review the facility	ent is not met as evidenced on, interview and document illed to ensure appropriate minated sharp for 1 of 12 iewed who required blood		Corrected		
	Findings include:					
	licensed practical n glucose (BG) readin hand sanitizer, obtation from the medication appropriately cleans utilized a lancet device blood sample from the use of the dispot tossed the used lan located at R22's be change her gloves prescribed dose of R22's abdomen. LF device located on the placed it into a red of needles/sharps) the procedure, LPN utilized hand sanitized was questioned whithe garbage receptately.	on 11/1/16 at 5:34 p.m., urse (LPN)-E checked a blooding for R22. LPN-E utilized at the individual glucometer of cart, donned gloves, sed the finger stick site and vice to obtain the necessary R22. Immediately following osable lancet device, LPN-E acet device into a garbage cand dide. LPN-E proceeded to and administered the insulin subcutaneously (SQ) in PN-E engaged the safety ne used insulin syringe and Sharps (container for disposal container. Upon completion of the removed her gloves and ter. on 11/1/16 at 5:45 p.m. LPN-E ether disposal of the lancet in acle was normal practice. "yes" the lancet could be vastebasket located in a				
	trained it was an ac the lancet in a resid designated Sharps	PN-E stated she had been ceptable practice to dispose lent's trash can rather than a disposal container. After question related to a				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00982	B. WING			, 3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
COLONIA	COLONIAL MANOR OF RALATON		14 EAST PO , MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 39	21375			
	removed the contar	et, LPN-E reapplied gloves, minated lancet device from and placed the device into the				
	director of nursing (was that all contam disposed of approp Sharp's containers. an acceptable pract	on 11/2/16, at 9:55 a.m. the (DON) stated her expectation inated sharps would be riately in a designated red The DON verified it was not tice to discard any sharps ncets, into a wastebasket.				
	revision date of Apr (2.) Contaminated s containers that are: resistant; (c.) Leaky Labeled or color-co established labeling impermeable and c	sharps will be discarded into (a.) Closable; (b.) Puncture proof on sides and bottom; (d.) ded in accordance with our				
	director of nursing of maintaining infection proper disposal of of director of nursing of	THOD OF CORRECTION: The could in-service all staff on n control standards related to contaminated lancets. The or designee could do random ampliance with standards of				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			12/13/16
		us treatment. Patients and right to be treated with				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
					C	;
		00982	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLONIA	AL MANOR OF BALA	TON	14 EAST POINT			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
21805	Continued From pa	ge 40	21805			
	courtesy and respe	ct for their individuality by rsons providing service in a				
	by: Based on observative review the facility facall light requests a manner for 3 of 3 re	ent is not met as evidenced on, interview and document ailed to promptly respond to nd/or speak in a respectful esidents (R6, R31, R29) who not provide dignified care.		Corrected		
	Findings include:					
	R6's annual Minimum Data Set (MDS) assessment dated 9/8/16, identified R6 required extensive assist of two staff with bed mobility and transfers. R6's annual MDS assessment further identified a Brief Interview for Mental Status (BIMS) score of 12 indicating mild cognition impairment. The MDS also identified R6 with no delusions or psychosis and identified R6 had minimum indicators of depression.					
	at 6:30 p.m. R6 wallight on. R6 was ob	of evening cares on 11/1/16, s observed to place his call served seated in his his bed with his shirt off.				
	was observed to wa R6's room and not check with him. NA without responding licensed practical n observed to walk do room and did not si though his call light	1/16 nursing assistant (NA)-G alk down the 100 wing past stop to answer call light nor A-G walked past R6's room to his call light. At 6:42 p.m. urse (LPN)-D and NA-G were own the 100 wing past R6's top to check on him even continued to be activated. At a observed to walk past R6's				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.: BOILBING.		С	
		00982	B. WING		11/0	3/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLONIAL	MANOR OF BALA	ΓON	14 EAST PO I, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
row F pw roof F a a a ti p o ros F ir this h F w th the C row a C " pa th q V d F	vas still on. At 6:52 R6's room and faile b.m. NA-A was obs wing from the nurse emained on and N. R6's p.m. LPN-D we R6's room while his and failed to respor- also noted to walk per ime and did not sto because and did not	ing on him even though light 2 p.m. NA-B again walked past d to check on him. At 6:54 erved to look down the 100 es station. R6's call light A-A did not check on R6. At as again observed to walk by call light continued to 'ring' not to R6's needs. NA-G was part R6's room at the same op to check on R6. At 6:57 ation assistant (TMA)-A was pown the 100 wing past R6's ight on and TMA-A did not 6. At 7:01 p.m. while observing action with an angry look on m. the surveyor questioned at he needed. R6 reported he ped, stating, "Where the hell is period ould respond to R6's call light. The surveyor exited the led NA-G and LPN-D and ould respond to R6's call light. The sarcastic manner. At 7:10 A-G entered R6's room and ed. R6 waited 40 minutes from the dot call light before staff.	21805			

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stated she felt staff should respond to any

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			7. BOLDING.		,	С	
		00982	B. WING			3/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
		HIGHWAY	14 EAST PO				
COLONIAL MANOR OF BALATON		ION	, MN 56115				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE	
21805	Continued From pa	ge 42	21805				
21003	resident call light wifurther stated staffs the resident what the will be back. The Didescribed was a digstated it was hard fework done with just better with 4 staff. If frequent call- ins ar staff as it was hard. The quarterly MDS identified R31 with a cognition; and minimal delusions. The MDS some behaviors tow required extensive activities of daily live.	ithin five minutes. The DON should at least stop by and ask ney need and notify them they ON verified the long wait time gnity issue. The DON also or the staff to get all of the three staff on and it was The DON said she had not has been unable to replace to find staff for hire. assessment dated 8/24/16, a BIMS of 15, indicating intact mal depression with no Sidentified that R31 exhibited wards others and self and assist of 1-2 staff with all ing (ADL's) except eating.	21000				
	R31 explained that rush and didn't do a on the evening shift would tell him he di daily. R31 stated h his teeth anyway ar burden to them. It w	and R31 responded, "no." staff seem to always be in a all of his cares. R31 stated that during bedtime cares, staff d not need to brush his teeth e tells staff he wants to brush and staff are resistive, as if is a was noted that R31 has his R31 further stated he had					
	always taken good the reason he still he verbalized that good him. R31 also state problem responding when he requests to garbage can beside staff get snippy or a will take an excessi	care of his teeth which was ad his natural teeth. R31 doral care was important to d staff seem to have a g to simple tasks; for example, hat staff move his fan and/or e him. R31 described that argue. R31 also stated staff ve amounts of time to respondes, it took around an hour to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00982	B. WING			3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COLONIAL MANOR OF RALATON			14 EAST PO I, MN 56115	D BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	light to get assistant put my call light on have to sit in an incompared to sit in an incompared to care for. R31 was the persons involved timeframe's to wait meal times and on self-transferred durassistance, knowin further stated the self-transferred durassistance, knowin further stated this lang towards him but was stated, "They use voword, I don't like it.' informed by staff if wanted he would have night. At completion whether he had repstaff and he indicated." During interview with 11/2/16, at 10:14 a. aware of any of the SW stated she met and R31 had not vower related to staffing would visit with R31 SW stated R31 wor interview but stated. On 11/2/16, at 12:10 been interviewed and him to brush his teen occurred on day and stated.	ge 43 se. R6 stated he uses his call ce with toileting. R6 stated, "I when I am incontinent and I ontinent brief for a long time. It awful upset." R31 stated he gth of time 2-3 times/week. It staff tell him there are others is unable to report the name of it. R31 indicated the worst for assistance were during weekends. R31 indicated he ing long wait times for staff git may be unsafe. R31 taff swear while caring for him. It guage was not directed its offensive to hear. R31 algar language to include the Firm R31 also stated he had been the didn't go to bed when they are to sleep in his chair all in of interview R31 was asked forted any of the concerns to the might have told LPN-B. The social worker (SW) on it is shall and the social worker (SW) on it is shall and any of the concerns to the gand/or staff attitude but it to hear about his concerns. The language to include the firm and the social worker (SW) on it is shall be a reliable person to the did get confused at times. The sum of the R31 told the SW this devening shifts. The SW the treat resident's with dignity and the sum of the	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00982	B. WING		11/0) 3/2016
				STATE, ZIP CODE D BOX 219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21805	this was certainly not also stated R31 told bed staff did not was confirmed that R31 desired daily oral cat was necessary to be confirmed that R31 not provided that m R31 was unable to involved staff, espename tag. The SW discussion with R31 and filed a Vulneral The SW also confir dislike of staff lang him. During interview on stated R31 had not these dignity issues when his call light is was unaware of R3 staff being rude to he on 11/2/16, at 12:5 (DON) was intervier response time durin DON stated she has concerns by the reswas reliable but was might not recall thin stated if she would complaints she would response time durin stated if she would complaints she would complaints she would recomplaints she would recomplaints she would recomplaints she would response time during (ADLs) assess required extensive stated in the stated if she would complaints she would recomplaints she was recomplaints.	ot dignified treatment. The SW d her when staff assist him to ash him. The SW also reported that although he are, he felt staff did not think it rush nightly. The SW also reported that oral care was orning. The SW stated that report the names of the cially if they did not wear a rindicated that after I she reported the incidents ole Adult report immediately. Med R31 had expressed his uage (cursing) used in front of a 11/2/16, at 12:27 p.m. LPN-B approached her about any of a LPN-A stated he will tell staff as not answered timely but she waiting and hour to toilet or nim. In a p.m. the director of nursing wed about R31's call light and other concerns. The donot been made aware of the sident or staff and verified R31 is sometimes demanding and and sps correctly. The DON further have been told about the	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00000			(
		00982			11/0	3/2016		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
COLONI	COLONIAL MANOR OF BALATON HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE		
21805	Continued From pa	ge 45	21805					
	upon staff for trans							
	stated there is a lor with toileting and sh for over an hour. Do R29 reported she w light but was able to the facility to inform R29 indicated this oweeks prior and extelephone call, staff assistance. R29 fur week, (she thought was so short staffer residents were drest to the supper meal room dressed in thi	on 11/1/16, at 1:35 p.m. R29 mg wait time for staff to assist the remained sitting on the toilet turing this particular incident, was unable to reach the call to access her phone, so called them she needed assistance. Occurred approximately 2 plained that after the fidid provide her with ther reported the previous it was a Sunday) the facility don the weekend that multiple seed in their night clothes prior and were taken to the dining s manner. R29 stated she did ght and she refused to go to essed for bed.						
	8:22 a.m. until 9:00 light was noted to b R29 was seated in reported she was with the toilet and then i stated this was a concept and the stat	observation on 11/2/16, from a.m. (38 minutes) R29's call be activated and sounding. Her wheelchair her room. R29 vaiting for staff to assist her to onto her recliner. R29 also ommon occurrence to wait an of time for staff to respond to further indicated in the past, ants" because she had to wait an interview on 11/2/16, at a seated in the wheelchair indicated there was a staff e name) that "isn't very nice, ispect".						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY MPLETED		
			A. BUILDING.		С			
		00982	B. WING			3/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE				
COLONIA	COLONIAL MANOR OF BALATON HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115							
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
21805	Continued From pa	ge 46	21805					
	call lights would be manner. Procedure: 1. All staff are responsible to answer of the control of	ified it was the facility policy answered in an efficient onsible to answer call lights. It general call light requests are inutes, when possible. It is an emergency call light for ests for assistance in the exceed two minutes, when the light for exceed two minutes, when the definition of the entire education and training in care of vulnerable adults and policies and procedures for eare. The facility could provide and training and monitor for						
	•	R CORRECTION: Twenty-one						
21870	MN St. Statute 144 Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870			12/13/16		
	residents shall have	nsive service. Patients and e the right to a prompt and se to their questions and						
	by: Based on documen facility failed to com	ent is not met as evidenced at review and interview the amunicate actions taken ag complaints of delayed call		Corrected				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00982	B. WING			C 03/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE				
COL ON	AL MANOR OF BALA	TON	Y 14 EAST PC) BOX 219				
OOLOIN	COLONIAL MANOR OF BALATON BALATON, MN 56115							
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	I SHOULD BE CON			
21870	Continued From pa	ge 47	21870					
	group over the past potential to affect al the facility.	expressed by the resident 12 months. This has the Il 29 residents who reside in						
	Findings include:							
	stated facility staff of concerns expressed R7 indicated conce social worker (SW), meeting but no upd taken is provided to staffing levels and of	11/1/16, at 4:17 p.m. R7 don't follow through with d at resident council meetings. rns are written down by the reviewed at next month's ate related to what actions are the council. R7 further stated call light response continues to tern, responding, "it's brought						
	reviewed for the pre revealed continuous related to slow call documentation: -11/18/15- waiting a -1/12/16- concerns a.m. and p.m2/11/16- call lights waiting a long time -3/23/16- call lights a timely manner5/24/16- some resi to an hour to have the -6/22/16- call lights be answered7/13/16- call lights a timely manner10/5/16- call lights time; some stated the slow call lights time; slow call lights tim	cil meeting minutes were evious 12 months and son-going resident complaints light response as noted in the long time for call lights. To f waiting for call lights during not answered very quickly and in the evening. The are still not being answered in idents have to wait 45 minutes their call lights answered. The are still taking a long time to are still not being answered in continue to have a long wait hey wait 45 minutes or more. Us months minutes nor						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
			A. BOILDING.			:		
		00982	B. WING			3/2016		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
COLONI	COLONIAL MANOR OF BALATON HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21870	Continued From pa	age 48	21870					
	any of the meeting 11/18/15.	minutes reviewed since						
	stated she attends documents the min explained that all docopy of the council responsibility of each follow up with spec concerns. The SW response time has awhile. When interviewed director of nursing copy of the residen aware of the concerelated to poor call DON indicated only manager attended confirmed she had	resident council meetings and outes/discussions. She epartment managers receive a minutes and it is the ch department manager to ific and/or widespread resident confirmed that poor call light been a concern expressed for a council minutes and was erns that residents expressed light response by staff. The the SW and the dietary council meetings and not communicated any notil with their concerns related se times.						
	Policy, dated 7/1/13 can improve comm residents, serve as identify quality of lif individual residents to effect change. See residents in their m	r of Balaton Resident Council 3, indicates Resident Council nunication between staff and a source of new ideas, help e and care issues, and help speak up in a collective voice staff members who assist onthly meetings include social anager, and director or (sic)						
	The administrator of revise policies and	THOD OF CORRECTION: or designee could review and procedures related to olution of grievances to ensure						

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A. BUILDING: COMPLE	
00982 B. WING 11/03/2	/2016
11/03/	/2010
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219	
COLONIAL MANOR OF BALATON BALATON, MN 56115	
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870 Continued From page 49 residents/families are informed of the resolution. The administrator or designee could educate all staff on the process. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	

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