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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1RJI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00982

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245552**

2. STATE VENDOR OR MEDICAID NO. (L2) **570014100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL MANOR OF BALATON**
(L4) **HIGHWAY 14 EAST PO BOX 219**
(L5) **BALATON, MN** (L6) **56115**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **12/19/2016** (L34

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **33** (L18)

13.Total Certified Beds **33** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	33			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 02/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/2/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245552 Y1	A. Building B. Wing Y2	12/20/2016 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0244	Correction	ID Prefix F0278	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(c)(6)	Completed	Reg. # 483.20(g) - (j)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0315	Correction	ID Prefix F0323	Correction	ID Prefix F0353	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.30(a)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0356	Correction	ID Prefix F0412	Correction	ID Prefix F0441	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.55(b)	Completed	Reg. # 483.65	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0520	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(o)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/13/2016	LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 34083	DATE 12/20/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/3/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245552 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/29/2016 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).

ITEM 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. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0133	12/25/2016	LSC K0321	12/25/2016	LSC K0345	11/02/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0346	12/09/2016	LSC K0354	12/09/2016	LSC K0372	12/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0712	11/02/2016	LSC K0741	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	2/1/2017	35482	12/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/2/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00982 Y1	A. Building B. Wing Y2	12/20/2016 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 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20800	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0510 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 1	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 4658.0520 Subp. 2 D	Completed	Reg. # MN Rule 4658.0520 Subp. 2 F.	Completed	Reg. # MN Rule 4658.0525 Subp. 5 A.B	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 144.651 Subd. 5	Completed	Reg. # MN St. Statute 144.651 Subd. 18	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	2/1/2017	34083	12/20/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1RJI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00982

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245552**

2. STATE VENDOR OR MEDICAID NO. (L2) **570014100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COLONIAL MANOR OF BALATON**
(L4) **HIGHWAY 14 EAST PO BOX 219**
(L5) **BALATON, MN** (L6) **56115**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **11/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **33** (L18)

13.Total Certified Beds **33** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	33			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 12/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

Informal Dispute Resolution - 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

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation were also completed at the time of the standard survey. An investigation of complaint # H5552012 was completed. The complaints were substantiated and deficiencies were cited at F241, F244, F282, F312, F315 and F353.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promptly respond to call light requests and/or speak in a respectful manner for 3 of 3 residents (R6, R31, R29) who	F 241	1. Corrective action as it applies to R31, R29, R6. DON B.R. discussed with each resident their concern with call light responses. Informed them of staff	12/13/16

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

Electronically Signed | 11/30/2016

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F 241	Continued From page 1 identified staff did not provide dignified care. 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. During observation of evening cares on 11/1/16, at 6:30 p.m. R6 was observed to place his call light on. R6 was observed seated in his wheelchair beside his bed with his shirt off. At 6:40 p.m. on 11/1/16 nursing assistant (NA)-G was observed to walk down the 100 wing past R6's room and not stop to answer call light nor check with him. NA-G walked past R6's room without responding to his call light. At 6:42 p.m. licensed practical nurse (LPN)-D and NA-G were observed to walk down the 100 wing past R6's room and did not stop to check on him even though his call light continued to be activated. At 6:51 p.m. NA-B was observed to walk past R6's room without checking on him even though light was still on. At 6:52 p.m. NA-B again walked past R6's room and failed to check on him. At 6:54 p.m. NA-A was observed to look down the 100 wing from the nurses station. R6's call light remained on and NA-A did not check on R6. At 6:55 p.m. LPN-D was again observed to walk by R6's room while his call light continued to 'ring' and failed to respond to R6's needs. NA-G was also noted to walk pat R6's room at the same	F 241	instruction that call lights should be answered within 5 minutes. And speak in respectful mannor. 2. All residents that depend on staff for assistance have the potential to be affected. 3. Measures and systemic changes to improve call light response in timely fashion were: All staff inservices held on 11/15/16 and 11/16/16 were informed of facility policy that lights were to be answered within 5 minutes. Random audits were done for all shifts on 11-7,8,9,12. Audits will continue bi-weekly for 1 month. 4. Follow up on responses to be discussed at department head weekly meetings and next QA with findings. 5. DON is responsible for task. Corrective action to be completed 12/20/16	

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time and did not stop to check on R6. At 6:57 p.m. trained medication assistant (TMA)-A was observed to walk down the 100 wing past R6's room, with the call light on and TMA-A did not stop to check on R6. At 7:01 p.m. while observing R6 from the hallway, it was noted he was seated in his room while located in his wheelchair beside the bed. R6 was noted to be pressing on his call light with repeated action with an angry look on his face. At 7:02 p.m. the surveyor questioned R6, asking him what he needed. R6 reported he wanted to get into bed, stating, "Where the hell is that nurse I need someone. Why the hell don't they come? I've been waiting for a while."

On 11/1/16, at 7:04 p.m. the surveyor exited the room and approached NA-G and LPN-D and asked staff if they could respond to R6's call light. During the conversation LPN-D stated, Oh great, "Mr. wonderful" in a sarcastic manner. At 7:10 p.m. LPN-D and NA-G entered R6's room and assisted him into bed. R6 waited 40 minutes from the time he activated his call light before staff queried him about his needs.

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 be back. The DON verified the long wait time described was a dignity issue. The DON also stated it was hard for the staff to get all of the work done with just three staff on and it was better with 4 staff. The DON said she had frequent call- ins and has been unable to replace

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staff as it was hard to find staff for hire.

The quarterly MDS assessment dated 8/24/16, identified R31 with a BIMS of 15, indicating intact cognition; and minimal depression with no delusions. The MDS identified that R31 exhibited some behaviors towards others and self and required extensive assist of 1-2 staff with all activities of daily living (ADL's) except eating.

During interview on 10/31/16, at 11:21 a.m. R31 was questioned whether staff treated him with dignity and respect and R31 responded, "no." R31 explained that staff seem to always be in a rush and didn't do all of his cares. R31 stated that on the evening shift during bedtime cares, staff would tell him he did not need to brush his teeth daily. R31 stated he tells staff he wants to brush his teeth anyway and staff are resistive, as if is a burden to them. It was noted that R31 has his own natural teeth. R31 further stated he had always taken good care of his teeth which was the reason he still had his natural teeth. R31 verbalized that good oral care was important to him. R31 also stated staff seem to have a problem responding to simple tasks; for example, when he requests that staff move his fan and/or garbage can beside him. R31 described that staff get snippy or argue. R31 also stated staff will take an excessive amounts of time to respond to call lights; at times, it took around an hour to get call light response. R6 stated he uses his call light to get assistance with toileting. R6 stated, "I put my call light on when I am incontinent and I have to sit in an incontinent brief for a long time. That makes me feel awful upset." R31 stated he had to wait that length of time 2-3 times/week. R31 also verbalized staff tell him there are others to care for. R31 was unable to report the name of

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the persons involved. R31 indicated the worst timeframe's to wait for assistance were during meal times and on weekends. R31 indicated he self-transferred during long wait times for staff assistance, knowing it may be unsafe. R31 further stated the staff swear while caring for him. R31 stated this language was not directed towards him but was offensive to hear. R31 stated,"They use vulgar language to include the F word, I don't like it." R31 also stated he had been informed by staff if he didn't go to bed when they wanted he would have to sleep in his chair all night. At completion of interview R31 was asked whether he had reported any of the concerns to staff and he indicated he might have told LPN-B.

During interview with the social worker (SW) on 11/2/16, at 10:14 a.m. she stated she was not aware of any of the concerns addressed by R31. SW stated she met with R31 on a monthly basis and R31 had not voiced any of the concerns to her related to staffing and/or staff attitude but would visit with R31 to hear about his concerns. SW stated R31 would be a reliable person to interview but stated he did get confused at times.

On 11/2/16, at 12:12 p.m. SW stated R31 had been interviewed and R31 verified staff came in his room and told him they didn't have time for him to brush his teeth. R31 told the SW this occurred on day and evening shifts. The SW stated staff should treat resident's with dignity and this was certainly not dignified treatment. The SW also stated R31 told her when staff assist him to bed staff did not wash him. The SW also confirmed that R31 reported that although he desired daily oral care, he felt staff did not think it was necessary to brush nightly. The SW also confirmed that R31 reported that oral care was

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not provided that morning. The SW stated that R31 was unable to report the names of the involved staff, especially if they did not wear a name tag. The SW indicated that after discussion with R31 she reported the incidents and filed a Vulnerable Adult report immediately. The SW also confirmed R31 had expressed his dislike of staff language (cursing) used in front of him.

During interview on 11/2/16, at 12:27 p.m. LPN-B stated R31 had not approached her about any of these dignity issues. LPN-A stated he will tell staff when his call light is not answered timely but she was unaware of R31 waiting and hour to toilet or staff being rude to him.

On 11/2/16, at 12:53 p.m. the director of nursing (DON) was interviewed about R31's call light response time during and other concerns. The DON stated she had not been made aware of the concerns by the resident or staff and verified R31 was reliable but was sometimes demanding and might not recall things correctly. The DON further stated if she would have been told about the complaints she would have handled it.

R29's most recent quarterly MDS assessment dated 10/17/16, identified a BIMS score of 15/15, indicating intact cognition. The activities of daily living (ADLs) assessment identified that R29 required extensive staff assistance with dressing, toileting, personal hygiene and total dependence upon staff for transfer.

When interviewed on 11/1/16, at 1:35 p.m. R29 stated there is a long wait time for staff to assist with toileting and she remained sitting on the toilet for over an hour. During this particular incident,

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R29 reported she was unable to reach the call light but was able to access her phone, so called the facility to inform them she needed assistance. R29 indicated this occurred approximately 2 weeks prior and explained that after the telephone call, staff did provide her with assistance. R29 further reported the previous week, (she thought it was a Sunday) the facility was so short staffed on the weekend that multiple residents were dressed in their night clothes prior to the supper meal and were taken to the dining room dressed in this manner. R29 stated she did not think this was right and she refused to go to the dining room dressed for bed.

During continuous observation on 11/2/16, from 8:22 a.m. until 9:00 a.m. (38 minutes) R29's call light was noted to be activated and sounding. R29 was seated in her wheelchair her room. R29 reported she was waiting for staff to assist her to the toilet and then into her recliner. R29 also stated this was a common occurrence to wait an extended amount of time for staff to respond to her call light. R29 further indicated in the past, she had "wet her pants" because she had to wait a long time.

During a subsequent interview on 11/2/16, at 11:18 a.m. R29 was seated in the wheelchair drinking coffee and indicated there was a staff (unable to report the name) that "isn't very nice, or does not treat me with respect".

The facility policy for "Call Lights: Answering" dated 5/2011, identified it was the facility policy call lights would be answered in an efficient manner.
Procedure:
1. All staff are responsible to answer call lights.

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F 241	Continued From page 7 2. Time to answer general call light requests are not to exceed 15 minutes, when possible. 3. Time to answer an emergency call light for requests and requests for assistance in the bathroom are not to exceed two minutes, when possible. 4. Call lights should be turned off promptly when addressing the stated need in a resident room.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to communicate actions taken related to the ongoing complaints of delayed call light response time expressed by the resident group over the past 12 months. This has the potential to affect all 29 residents who reside in the facility. Findings include: During interview on 11/1/16, at 4:17 p.m. R7 stated facility staff don't follow through with concerns expressed at resident council meetings. R7 indicated concerns are written down by the social worker (SW), reviewed at next month's meeting but no update related to what actions are taken is provided to the council. R7 further stated	F 244	1. R7 visited with concerns with call light not being answered timely. He states its usually in the evening when he wants help with his CPAP.Resident informed that the PM staff aware of his need. 2. All residents of the facility are potentially affected by the failure of staff to follow up on residents complaints. 3. S/S and DON have discussed need for DON to be present at resident council. 4. Staff attending resident group will start to include the DON along with S/S and dietary so that issues may be addressed promptly. Documentation of same will be done by DON and S/S promptly after followup. DON and S/S will followup with resident concerns promptly to improve	12/13/16

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F 244	Continued From page 8 staffing levels and call light response continues to be an ongoing concern, responding, "it's brought up all the time". The Resident Council meeting minutes were reviewed for the previous 12 months and revealed continuous on-going resident complaints related to slow call light response as noted in the documentation: -11/18/15-waiting a long time for call lights. -1/12/16-concerns of waiting for call lights during a.m. and p.m. -2/11/16-call lights not answered very quickly and waiting a long time in the evening. -3/23/16-call lights are still not being answered in a timely manner. -5/24/16-some residents have to wait 45 minutes to an hour to have their call lights answered. -6/22/16-call lights are still taking a long time to be answered. -7/13/16-call lights are still not being answered in a timely manner. -10/5/16-call lights continue to have a long wait time; some stated they wait 45 minutes or more. No review of previous months minutes nor follow-up regarding call light concerns noted in any of the meeting minutes reviewed since 11/18/15. During interview on 11/3/16, at 8:52 a.m. the SW stated she attends resident council meetings and documents the minutes/discussions. She explained that all department managers receive a copy of the council minutes and it is the responsibility of each department manager to follow up with specific and/or widespread resident concerns. The SW confirmed that poor call light response time has been a concern expressed for awhile.	F 244	resident satisfaction. Results to be reviewed at QA meetings. 5. DON and S/S are responsible for followup and documentation.Completion date 12-20-16	

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F 244	Continued From page 9 When interviewed on 11/3/16, at 11:43 a.m. the director of nursing (DON) stated she receives a copy of the resident council minutes and was aware of the concerns that residents expressed related to poor call light response by staff. The DON indicated only the SW and the dietary manager attended council meetings and confirmed she had not communicated any updates to the council with their concerns related to call light response times. The Resident Council Policy, dated 7/1/13, indicates Resident Council can improve communication between staff and residents, serve as a source of new ideas, help identify quality of life and care issues, and help individual resident speak up in a collective voice to effect change. Staff members who assist residents in their monthly meetings include social services, dietary manager, and director or (sic) nursing.	F 244		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal cares as directed by the care plan for 6 of 10 residents (R3, R5, R6, R20, R14, R9) reviewed. Findings include:	F 282	1. Corrective action for cited residents R3, R5, R20, R14, R19, had facial hair groomed when noted. R6 was set up with a dental appointment. Staff instructed to toilet R20 every 2 hours or less if needed. R20 is able tell staff when needs to have	12/13/16

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F 282	Continued From page 10 The quarterly Minimum Data Set (MDS) assessment dated 9/8/16, identified R3 required extensive assistance with grooming. R3's care plan, last revised for grooming, on 6/24/16 identified R3 had a self care deficit with grooming and bathing related to dementia and arthritis. The care plan further identified R3 had memory loss and impaired cognition and was dependent upon staff assist for bathing and grooming. During initial observation in the dining room on 11/1/16, at 11:33 a.m. R3 was observed to have long facial hair on her chin and under her nose. The facial hair was easy to visualize during conversation. During observation on 11/2/16, at 6:57 a.m. R3 was seated in the hallway in her wheelchair by the nurses station. R3 stated she had her bath this morning; however, visible long facial hair was present. When interviewed at the time of the observation, R3 stated she did not like hair on her face, was unaware she had facial hair but indicated she would like the hair shaved. R3 stated she did not know who was supposed to shave her. During interview with the hair dresser on 11/2/16, at 7:27 a.m. she stated she did not remove facial hair nor perform fingernail grooming. She stated she frequently notices resident's with long facial hair while providing hair care at the facility. During interview on 11/2/16, at 9:33 a.m. nursing assistant (NA)-D stated staff were expected to provide facial hair grooming and nail care during resident baths. NA-D stated she had not given R3 her bath this morning but that NA-F had been	F 282	bowel movement not always for voiding. R5, R14 both had nail care done by licenced staff as are diabetic. R9 care plan is now current with NAR assignment to reflect current plan of care. 2. All residents well being has the potential to be affected by non adherence of care plans. 3. All nursing staff have been instructed that care plans need to be followed on meeting held 11/15/16, 2016. 4. Changes to prevent recurrence started on 11-10-16 with nail care and facial hair audits daily for 1 week by assigned staff. Audits will continue weekly for 1 month. All nursing staff informed of resident care plan per toileting in report and during all staff meeeting on 11-15, 11/16/2016. Toileting care plans for residents with assessment changes as noted by MDS and RN nurse will be placed on staff assignment sheets and kept current. Will also be addressed at nursing meeting on the 11/30/2016.Findings to be followed up at QA. 5. Responsible party DON, MDS nurse	

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assigned. NA-D verified she noted that R3 did not have her facial hair removed/shaved that morning. At 9:38 a.m. during interview with NA-F it was verified R3 had not received facial hair removal/grooming during the bath. NA-F confirmed she had not shaved R3 but should have provided the grooming as expected.

R6's annual MDS assessment dated 9/8/16, identified R6 required extensive assist of two staff with all activities of daily living (ADL's) and also identified R6 free of any oral or dental concerns.

R6's care plan revised care plan dated 9/21/16, identified R6 with an alteration in dental status related to the use of upper dentures. The care plan identified staff would provide oral hygiene by brushing his denture and cueing him to brush his own teeth.

During initial observation of R6 on 10/31/16, at 10:39 a.m. R6 was noted to have natural teeth on his lower gum line that were missing and broken.

During observation of R6 on 11/1/16 at 4:35 p.m. it was noted that multiple teeth were missing on the lower gum and that teeth were somewhat protruding from the oral cavity. There was evidence of decay at the gum line of 2 teeth in the front of the lower gums R6's lower natural teeth were noted to be cracked , discolored and had excessive food debris.

During interview with R6 on 11/2/16 at 8:11 a.m. R6 stated staff were supposed to do his oral cares but they forgot sometimes. R6 stated staff failed to complete his dental cares last evening (11/1/16) and this morning (11/2/16).

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R20's significant change MDS dated 8/12/16 identified R20 required extensive assist of two staff with toileting. R20's care plan dated 8/18/16, identified R20 with an alteration in bladder incontinence related to functional impairment from dementia, psychotropic drug use, pain and immobility. The care plan identified R20 had a toileting schedule to be toileted every two hours.

During initial observation of R20 on 10/31/16, at 2:20 p.m. R20 was seated in her wheelchair in her room between her bathroom and room. There was noted to be a puddle of urine on the floor in the middle of room. At the time of the observation, trained medication assistant (TMA)-A was made aware of the observation and entered R20's room to assist R20. TMA stated R20 was dependent on staff and mechanical lift to toilet.

During observation of cares on 11/2/16, at 6:45 a.m. R20 was observed seated in hallway by nurses station in her wheelchair with eyes closed.

During observation of morning cares on 11/2/16, at 6:58 a.m. R20 was observed seated in the seated in hallway by nurses station. NA-B stated R20 was assisted out of bed at approximately 6:15 a.m. at which time she was toileted.

On 11/2/20 at 7:32 a.m. R20 was wheeled into dining room and placed seated at table in her wheelchair.

On 11/2/16, at 9:02 a.m. R20 remained seated in the dining room at table.

On 11/2/20, at 9:21 a.m. R20 remained in dining room and was observed slowly wheeling herself

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F 282	Continued From page 13 towards the exit door. On 11/2/16, at 9:24 a.m. R20 wheeled herself out of dining room and into hallway by nurses station. R20 utilized her hands and feet to propel the wheelchair. On 11/2/16, at 9:26 a.m. R20 was seated in her wheelchair looking at newspaper while seated in the hallway by nurse station. On 11/2/16, at 9:46 a.m. NA-D assisted R20 to the bathroom at the nurses station as the hairdresser was waiting to do R20's hair and stated staff needed to toilet R20 before her hair was fixed. R20 was toileted 3 hours and 30 minutes after her assistance with toileting when gotten up. After toileting NA-D stated R20 was moderately wet when toileted and in addition, voided some when toileted. During observations on 10/31/16, at 11:10 a.m., and again on 11/2/16, at 1:14 p.m. R5's fingernails were observed to be long, jagged with dark debris under the nail on both hands. Review of R5's Cumulative Diagnosis List dated 10/12/16, included diagnosis of diabetes mellitus. Review of R5's quarterly Minimum Data Set (MDS) assessment dated 9/19/16, indicated R5 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment and needing extensive assistance of one staff member with personal hygiene. Review of R5's care plan dated 9/16, identified R5 with a functional deficit in personal hygiene	F 282		

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and required staff assistance with bathing and grooming.

When interviewed on 11/2/16, at 7:15 a.m. NA-B indicated R5's nail care is completed on bath days as R5 required assistance. NA-B further included R5 had diabetes and therefore nail care was only provided by the licensed nurses. A follow-up interview with LPN-B on 11/2/16, at 7:33 a.m. confirmed R5's nail care is performed weekly by licensed staff/nurse.

Review of R5's treatment record dated October 2016, included a nursing order to trim R5's fingernails weekly on bath days (Monday mornings). Review of the documentation indicated nail care had been completed on 10/31/16, but R5's nails continued to be long, jagged with notable debris on 11/2/16.

During interview and observation on 11/2/16, at 1:17 p.m. with NA-B, it was confirmed R5's fingernails were long, jagged and had dark debris under the nail.

During interview on 11/3/16, at 11:40 a.m. the DON indicated she would have expected R5's nails to be trimmed by the licensed nurse per nursing orders and as needed.

During initial interview and observation of R14 on 11/1/16, at 1:49 p.m. R14 was noted to have jagged fingernails with sharply cut angles. R14 stated, "the girl did them in a hurry". R14 indicated she did not like how they were trimmed. R14's nails were polished but heavily worn.

During observation on 11/2/15, at 6:59 a.m. R14's nails remained jagged with sharply cut angles.

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F 282	Continued From page 15 During interview on 11/2/16, at 7:15 a.m. NA-B indicated R14's fingernails should be cleaned and trimmed on bath days. Review of R14's admission MDS dated 8/9/16, indicated R14 had a BIMS score of 4 indicating severe cognitive impairment and requiring extensive assistance of 1 staff with personal hygiene needs. 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. Review of R14's Bath Report dated 10/28/16, did not indicate whether the residents fingernails had been trimmed. During interview on 11/3/16, at 11:40 a.m. the DON indicated she would have expected R14's fingernails to be trimmed per resident's liking on 10/28/16, and as needed as directed on the plan of care. The facility's policy titled Care of Fingernails/Toenails revised 10/2010, indicates nail care includes daily cleaning and regular trimming. It directs to remove dirt from around and under each nail with an orange stick, trim fingernails in an oval shape, and to smooth the nails with a nail file or emery board. R9's quarterly MDS dated 8/25/16, indicated severe cognitive impairment per staff interview, required total assistance of two staff for transfers and was always incontinent of bowel and bladder.	F 282		

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Review of R9's care plan updated 8/27/16, instructed nursing to check and change for urinary incontinence every 2 hours and transfer with the use of a Hoyer (mechanical device used to lift) and two staff.

During interview on 11/1/16, at 5:35 p.m. NA-A states R9 gets up on a commode using a stand lift (a mechanical standing device) before supper but after that is transferred using a Hoyer lift and and requires only check and change of incontinent briefs.

During interview on 11/2/16, at 1:30 p.m. NA-F stated R9 is placed on a commode after breakfast using the Stand lift and two assist.

During interview on 11/2/16, at 1:39 p.m. NA-B indicated R9 is toileted on commode with a Stand lift once/day shift.

During interview on 11/3/16, at 8:17 a.m. NA-I stated R9 transfers with a Stand lift to the commode before and after every meal. NA-I stated a Stand lift had been utilized with morning cares and R9 had been assisted to the commode prior to the breakfast meal. NA-I then verified this information per R9's restorative charting record and the care list.

During interview on 11/3/16, at 10:50 a.m. RN-B stated R9 is to be transferred with a Hoyer lift and is checked and changed every 2 hours for incontinence care. RN-B verified this change had occurred on 8/27/16 per the care plan as sitting on a commode had been upsetting for R9. RN-B confirmed the staff care list and restorative charting record did not have the correct information communicated from the current care

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F 282	Continued From page 17 plan and NA's were not following care plan related to transfers and toileting. When interviewed on 11/3/16, at 11:15 a.m. the DON verified staff had incorrect information and had not been following the plan of care as directed. The DON confirmed she would expect the restorative sheet and care lists used by NA's to be accurate per R9's care plan. The facility's policy for Care Plans-Comprehensive revised 10/2010, indicates care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change.	F 282		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming cares for 5 of 10 residents (R3, R6, R20, R5, R14) reviewed who were unable to perform grooming and personal hygiene without extensive staff assistance. Findings include:	F 312	1. R3, R20, R5, R14, did have facial hair and nail care done by staff. R5 and R14 were done by licensed staff as are diabetic. R6 has a dental appointment made as requested. 2. All residents that depend on staff for cares are at risk to be affected if care plan not being followed.	12/13/16

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F 312	Continued From page 18 The quarterly Minimum Data Set (MDS) assessment dated 9/8/16, identified R3 with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognition impairment and also identified R3 required extensive assistance of staff with grooming. R3's care plan, last revised for grooming, on 6/24/16, identified that R3 had a self care deficit with grooming and bathing related to dementia and arthritis and was dependent upon staff assistance with bathing and grooming needs. The care plan further identified R3 had memory loss and impaired cognition. During initial observation in the dining room on 11/1/16, at 11:33 a.m. R3 was observed to have long facial hair on her chin and under her nose. The facial hair was easy to visualize during conversation. During observation on 11/2/16, at 6:57 a.m. R3 was seated in the hallway in her wheelchair by the nurses station. R3 stated she had her bath this morning; however, visible long facial hair was present. When interviewed at the time of the observation, R3 stated she did not like hair on her face, was unaware she had facial hair but indicated she would like the hair shaved. R3 stated she did not know who was supposed to shave her. During interview with the hair dresser on 11/2/16, at 7:27 a.m. she stated she did not remove facial hair nor perform fingernail grooming. She stated she frequently notices resident's with long facial hair while providing hair care at the facility.	F 312	3. Policies related to grooming and nail care were reviewed at staff meeting on 11/15,16,/2016. They will also be reviewed at Nursing meeting on 11/30/16. 4. Nail care and facial hair care on females were audited on 11/10/16. Audits were done daily for 1 week and will be done weekly for a month. Dental assessments carried out by MDS nurse will be reviewed for 1 month for follow up for needed dental visits. Findings to be followed with at QA. 5. DON, Licensed nurses, MDS nurse responsible. Completion by 12/13/16	

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During interview on 11/2/16, at 9:33 a.m. nursing assistant (NA)-D stated staff were expected to provide facial hair grooming and nail care during resident baths. NA-D stated she had not given R3 her bath this morning but that NA-F had been assigned. NA-D verified she noted that R3 did not have her facial hair removed/shaved that morning. At 9:38 a.m. during interview with NA-F it was verified R3 had not received facial hair removal/grooming during the bath. NA-F confirmed she had not shaved R3 but should have provided the grooming as expected.

R6's annual MDS assessment dated 9/8/16, identified R6 required extensive assist of two staff with all activities of daily living (ADL's). The MDS further identified a BIMS score of 12 indicating mild cognitive impairment and no delusions or psychosis and had minimum indicators of depression. Furthermore, the assessment identified R6 free of any oral or dental concerns.

R6's care plan revised care plan dated 9/21/16, identified R6 with an alteration in dental status related to the use of upper dentures. The care plan identified staff would provide oral hygiene by brushing his denture and cueing him to brush his own teeth.

During initial observation of R6 on 10/31/16, at 10:39 a.m. R6 was noted to have natural teeth on his lower gum line that were missing and broken.

During observation of R6 on 11/1/16 at 4:35 p.m. it was noted that multiple teeth were missing on the lower gum and that teeth were somewhat protruding from the oral cavity. There was evidence of decay at the gum line of 2 teeth located in front of the lower gums R6's lower

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F 312	Continued From page 20 natural teeth were noted to be cracked , discolored and had excessive food debris. During interview with R6 on 11/2/16 at 8:11 a.m. R6 stated staff were supposed to do his oral cares but they forgot sometimes. R6 stated staff failed to complete his dental cares last evening (11/1/16) and this morning (11/2/16). During observation of cares on 11/1/16, at 4:06 p.m. R20 was located in her wheelchair adjacent to the nurses' station. R20 was noted to have long facial hairs on her chin and sides of face which was visible during interaction with the resident. During observation of cares on 11/2/16, at 6:58 a.m. R20 was observed seated in her wheelchair nearby the nurses station and long facial hairs were visible during interaction with the resident. During interviews with NA-C and NA-F at 11/2/16, at 12:47 p.m. staff were questioned about the presence of R20's facial hair. Both NA's stated R20 had a bath the morning of 10/31/16 and the facial hairs should have been hair clipped during the bath. Both staff confirmed it had not been done. During interview with the director of nursing (DON) on 11/2/16, at 2:00 p.m. it was verified staff should provide shaving services to all resident's on bath days as needed. The facility policy for "Shaving the Resident", revised 10/2010, identified the purpose of the policy was to promote cleanliness and to provide clean skin care and identified: 1. Review resident's care plan to assess for any	F 312		

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special needs of the resident.
2. Assemble equipment and supplies as needed.
The policy did not include directions for when to shave residents or how to shave female residents, but just included basic guidelines for shaving. No other policy for shaving was submitted by facility.

During observation on 10/31/16, at 11:10 a.m., and again on 11/2/16, at 1:14 p.m. R5's fingernails were observed to be long, jagged with dark debris under the nail on both hands.

Review of R5's Cumulative Diagnosis List dated 10/12/16, included diagnosis of diabetes mellitus. Review of R5's quarterly Minimum Data Set (MDS) assessment dated 9/19/16, indicated R5 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment and needing extensive assistance of one staff member with personal hygiene.

Review of R5's care plan dated 9/16, identified R5 with a functional deficit in personal hygiene and required staff assistance with bathing and grooming.

During interview on 11/2/16, at 7:15 a.m. NA-B indicated nail care for R5 is completed on bath days and R5 required assistance. NA-B further included R5 had diabetes and therefore nail care was only provided by the licensed nurses. Follow-up interview with licensed practical nurse (LPN)-B on 11/2/16, at 7:33 a.m. confirmed R5's nail care is done weekly by the licensed nurse.

Review of R5's treatment record dated October 2016, included a nursing order to trim R5's fingernails weekly on bath days (Monday

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mornings). Review of the documentation indicated nail care had been completed on 10/31/16; however, R5's nails remained long and jagged with notable debris on 11/2/16.

During interview and observation on 11/2/16, at 1:17 p.m. with NA-B, confirmed R5's fingernails were long, jagged and had dark debris under the nail.

During interview with the DON on 11/3/16, at 11:40 a.m. it was indicated she expected R5's nails to be trimmed by the licensed nurse per nursing orders and as needed.

During initial interview and observation of R14 on 11/1/16, at 1:49 p.m. R14 was observed to have jagged finger nails with sharply cut angles. R14 stated, "the girl did them in a hurry". R14 indicated she did not like how they were trimmed. R14's nails were polished but heavily worn.

During observation on 11/2/15, at 6:59 a.m. R14's nails remained jagged with sharply cut angles.

Review of R14's admission MDS dated 8/9/16, indicated R14 had a BIMS score of 4 indicating severe cognitive impairment and requiring extensive assistance of 1 staff with personal hygiene needs.

Review of R14's care plan dated 9/21/16, directed NA to do nail care weekly on bath days (Friday morning) and required extensive assistance of 1 staff with grooming.

Review of R14's Bath Report dated 10/28/16, did not indicate whether the residents fingernails had been trimmed.

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	245552	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 23 During interview on 11/2/16, at 7:15 a.m. NA-B indicated R14's fingernails should be cleaned and trimmed on bath days. During interview on 11/3/16, at 11:40 a.m. the DON indicated she would have expected R14's fingernails to be trimmed per residents liking on 10/28/16, and as needed. The facility's policy titled Care of Fingernails/Toenails revised 10/2010, indicates nail care includes daily cleaning and regular trimming. It directs to remove dirt from around and under each nail with an orange stick, trim fingernails in an oval shape, and to smooth the nails with a nail file or emery board.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting services for 2 of 2 residents (R20, R31) reviewed who required staff assistance with toileting needs.	F 315	1. R20, R31 toileting plans indicate bladder incontinence with a toileting plan. Staff instrucucted to toilet according to POC. R31 does not always allow staff to	12/13/16

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F 315	Continued From page 24 Findings include: R20's significant change Minimum Data Set (MDS) assessment dated 8/12/16, identified R20 required extensive assist of two staff with toileting. The MDS further identified R20 was frequently incontinent of urine and did not have a toileting program and identified there had been a previous toileting plan which demonstrated R20 had reduced incontinence with the implemented plan. R20's bladder assessment (3 day toileting log from 8/13/16-8/15/16) identified R20 was able to identify the need to void and was able to void in toilet when toileted every two hour. Even though on some occasions R20 was incontinent of urine at times of toileting,(documented-small amount), R20 was able to finish voiding when toileted. R20's care plan dated 8/18/16, identified R20 with an alteration in bladder incontinence related to functional impairment from dementia, psychotropic drug use, pain and immobility. The care plan identified R20 had a toileting schedule to be toileted every two hours. During initial observation of R20 on 10/31/16, at 2:20 p.m. R20 was seated in her wheelchair in her room and a puddle of urine was noted on the floor in the middle of room. At the time of the observation, trained medication assistant (TMA)-A was made aware of the observation and entered R20's room to assist R20. TMA-A stated R20 was dependent on staff and a mechanical lift to transfer to the toilet. TMA-A verified the urine odor and incontinence.	F 315	toilet as planned and denies the need to toilet even though he can be already wet. 2. All residents with incontinence may be affected with worsening incontinence if toileting plans are not followed. 3. All direct care staff informed of following toileting plans of care at meeting on 11/15,16/2016. 4. Monitoring to be done with toileting audits on these 2 affected residents x 3. Compliance to be evaluated by Nurse Manager for progress on either improvment or decline and make care plan changes as needed. Also will review necassary actions with nursing at nusing meeting on 11/30/2016. Audits at findings to be discussed at QA meetings 5. Nurse manager responsible party. Completion date 12/13/2016	

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F 315	Continued From page 25 During observation of cares on 11/1/16, at 4:06 p.m. R20 was seated in the hallway by nurses station and was noted to have a strong urine odor present when standing nearby. During observation of cares on 11/1/16, at 5:05 p.m. R20 was assisted to the toilet located near the nurses station. Nursing assistant (NA)-A (who assisted R20) verified R20 was incontinent of urine when taken into the bathroom and stated she also noted the strong urine odor present but was unsure where it was from. During observation of cares on 11/2/16, at 6:45 a.m. R20 was seated in the hallway by nurses' station in her wheelchair with eyes closed. At 6:58 a.m. R20 remained seated in the wheelchair in the same location. When interviewed at this time, NA-B stated R20 was assisted out of bed at approximately 6:15 a.m. and was toileted at that time. At 7:32 a.m. R20 was wheeled into the dining room and seated at a table. At 9:02 a.m. R20 remained seated in the dining room at the same table. At 9:21 a.m. R20 left the dining room by slowly wheeling herself toward the exit door. At 9:24 a.m. R20 wheeled herself into the hallway located by the nurses' station. At 9:26 a.m. R20 remained seated in her wheelchair looking at newspaper in the same location. The hairdresser, who was waiting to fix R20's hair, stated staff needed to toilet R20 before she arrived in the beauty shop. At 9:46 a.m. NA-D assisted R20 into the bathroom located near the nurses station. R20 was toileted 3 hours and 30 minutes (6:15 a.m. -9:46 a.m.) after she was assisted with morning cares. After toileting was provided, NA-D confirmed R20 was moderately wet when assisted and also verified R20 voided some urine while on the toilet.	F 315		

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When interviewed on 11/2/16, at 6:50 a.m. nursing assistant (NA)-D stated R20 had the ability to void in the toilet and sometimes remained dry when toileted on a two hour schedule.

When interviewed on 11/2/16, at 1:16 p.m. registered nurse (RN)-B verified R20 was on a two hour toilet schedule and verified staff should toilet her at a minimum of every two hours.

The quarterly MDS assessment dated 8/24/16, identified R31 with a BIMS of 15, indicating intact cognition; and minimal depression with no delusions. The MDS identified that R31 required extensive assist of 1-2 staff with all activities of daily living (ADL's) except eating. The MDS assessment indicated R31 was frequently incontinent (7 or more episodes of urinary incontinence, at least 1 episode of continent voiding).

During interview on 10/31/16, at 11:21 a.m. R31 was questioned whether staff treated him with dignity and respect and R31 responded, "no." R31 stated staff will take an excessive amounts of time to respond to call lights; at times, it took around an hour to get call light response. R6 stated he uses his call light to get assistance with toileting. R6 stated, "I put my call light on when I am incontinent and I have to sit in an incontinent brief for a long time. That makes me feel awful upset." R31 stated he had to wait that length of time 2-3 times/week. R31 indicated the worst timeframe's to wait for assistance were during meal times and on weekends.

When interviewed on 11/2/16, at 12:53 p.m. the

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F 315	Continued From page 27 director of nursing (DON) about R31's call light response time and stated if she would have been told about the complaints she would have handled it. The facility provided a policy titled Urinary Continence and Incontinence- Assessment and Management. The policy identified how assessments would be conducted but did not identify staff's responsibility to ensure interventions were followed. No other policy was provided.	F 315		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		12/13/16

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F 353	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure sufficient staffing was available to meet resident needs related to appropriate grooming, oral care, timely toileting and timely call light response for 8 of 29 residents (R3, R5, R6,R9, R14, R20, R29, R31). This had the potential to affect all 29 residents in the facility. Findings include: Based on observation, interview and document review the facility failed to promptly respond to call light requests and/or speak in a respectful manner for 3 of 3 residents (R6, R31, R29) who identified staff did not provide dignified care. Refer to F241. Based on document review and interview the facility failed to communicate actions taken related to the ongoing complaints of delayed call light response time expressed by the resident group over the past 12 months. This has the potential to affect all 29 residents who reside in the facility. Refer to F244. Based on observation, interview and document review the facility failed to provide personal cares as directed by the care plan for 6 of 10 residents (R3, R5, R6, R20, R14, R9) reviewed. Refer to F282. Based on observation, interview and document review the facility failed to provide grooming cares for 5 of 10 residents (R3, R6, R20, R5, R14) reviewed who were unable to perform grooming and personal hygiene without extensive staff assistance. Refer to F312.	F 353	1.Corrective action as it applies to R3, R5, R16, R20, R31. Residents informed that facility will supply staffing to meet their needs. 2.This has the potential to affect all residents in the facility that depend on facility for needs. 3.Facility will continue to recruit more NAR staffing. Minimum staff needs with 33 residents is 4 NARs.If we are down to 5 less residents it is 3 NARs along with the TMA who is also an NAR for the am shift. PM shift is 3 NARs and a TMA that spends the first 3 hours and the last 1 hour of her shift as an NAR. Nights have 1 NAR. This is adequate to meet residents needs and is over the minmum required state staffing levels. IF staffing is not adequate facility will reject new residents until staffing is adequate.(Facility will continue to use pool staff when available). Staff will be reassigned to specific shift needs. Charge nurses will assist in filling NAR shifts as needed. Facility will educate nursing staff at nurses meeting on 11/30/2016 about meeting resident needs and staffing guidelines. All staff also informed of staffing concerns and guidelines on 11/15/2016 and 11/16/2016. DON and S/S will re-interview directly affected residents by 12/8/2016 for needs being met. 4.Residents staffing issues and audits of cares will be discussed at weekly department head meetings and QA to dtermine if we have adequate staffing. 5.Responsible parties are DON and	

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F 353	Continued From page 29 Based on observation, interview and document review the facility failed to provide timely toileting services for 2 of 2 residents (R20, R31) reviewed who required staff assistance with toileting needs. Refer to F315 Additional Interviews: During an interview on 11/1/16, at 5:26 p.m. nursing assistant (NA)-I -stated there are only 2 NAs working from 2:00 p.m. until 4:00 p.m. to provide care for 29 residents until a 3rd NA arrived to assist. The time frame for only having 2 NAs working can vary from 2-8 hours depending on the day and whether anyone is willing to come in. NA-I indicated there is always a nurse on duty but it does take awhile to get to everyone. When interviewed on 11/2/16, at 10:14 a.m. NA-C indicated at times the facility is "staff challenged" or working short. NA-C indicated the aide staffing is normally 4 NAs and 1 restorative NA; for example, this morning there were only 3 nursing assistant on duty- 1 person on the 100 wing and 2 persons on the 200 wing. NA-C indicated this was according to the schedule. NA-C stated, "there is not enough staff for all the shifts here" and indicated short staffing occurs at least 2 x weekly. NA-C confirmed there were times that residents had urinary/incontinent episodes as a 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	F 353	Administrator. Completetion date 12/13/2016.	

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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 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 the Nurse supervisor/Charge Nurse, as a minimum, is responsible for: Assigning work schedules and staffing to meet the needs of residents; providing direct resident care as necessary or appropriate, and other tasks and functions that may become necessary.

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	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 2, 2016. At the time of this survey, Colonial Manor of Balaton was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/28/2016

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Colonial Manor of Balaton was constructed in 1973, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 33 beds and had a census of 29 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=F	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance	K 133		12/25/16

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K 133	Continued From page 2 with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain a 2-hour separation is provided in accordance with 8.2.1.3. The deficient practice could affect 29 out of 29 residents. Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 Findings include:	K 133	1. Maintenance staff will make the neccessary repairs (fire caulking) to seal up all penatrations in the 2 hour fire seperation wall between Colonial Manor of Balaton and the Assisted Living Facility in accordance with 18/19.1.3.2 or 18/19.1.3.4. 2. Completion date 12/25/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 133	Continued From page 3 On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, observation revealed a penetration around a sprinkler pipe was observed above the lay-in ceiling in the 2 hour fire separation wall between Colonial Manor and the Assisted Living Facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 133		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		12/25/16

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K 321	Continued From page 4 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain hazardous areas are protected by a fire barrier having 1-hour fire resistance rating. The deficient practice could affect 15 out of 29 residents. Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)	K 321	1. Maintenance staff will make the appropriate repairs (fire caulking) in accordance with 8.7.1 and 8.4 2. Completion date 12/25/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	

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K 321	Continued From page 5 Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, observation revealed penetrations in the sheetrock wall within the Oxygen Storage Room. This deficient practice was verified by the Facility Maintenance Director.	K 321		
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 29 out of 29 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345	1. Maintenance staff will test the DACT system after each fire drill. If the fire alarm was not tested during a fire drill then the next day (8am-5pm)the DACT system will be tested by tripping the fire alarm and contacting the monitoring company per 9.7.5, 9.7.7, 9.7.8, and NFPA 25. 2. Completion date 11/02/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility	11/2/16

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K 345	Continued From page 6 acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation reviewed revealed that the DACT System was not tested monthly during the 2016 fire drills conducted on the night shift. This deficient practice was verified by the Facility Maintenance Director.	K 345	Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	
K 346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. The deficient practice could affect 29 out of 29 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the	K 346	1. Correct and update the "Fire Alarm - Out of Service" policy and insert it into company policy hand book. 2. Completion date 12/9/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	12/9/16

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K 346	Continued From page 7 fire alarm system has been returned to service. 9.6.1.6 Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current staff contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346		
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 29 out of 29 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been	K 354	1. Correct and update the "Sprinkler System - Out of Service" policy and insert it into company policy hand book. 2. Completion date 12/9/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility	12/9/16

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K 354	Continued From page 8 determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current staff contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354	Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system	K 372		12/25/16

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K 372	Continued From page 9 in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1. (1). This deficient practice could affect 29 of 29 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, observation revealed penetrations above the lay-in ceiling around conduit pipes and sprinkler pipes in the smoke barrier wall at the 100 Wing and 200 Wing Smoke Barriers. These deficient practices were verified by the Facility Maintenance Director.	K 372	1. Maintenance staff will make the appropriate repairs (fire caulking)to seal the penetrations above the lay-in ceiling around conduit pipes and sprinkler pipes in the smoke barrier wall at the 100 Wing and 200 Wing Smoke Barriers in accordance with 19.3.7.3, 8.6.7.1(1) 2. Completion date 12/25/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		11/2/16

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K 712	Continued From page 10 conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 29 of 29 residents Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation reviewed revealed that a fire drill was not conducted during the	K 712	1. Maintenance staff will conduct fire drills once per shift per quarter for all staff at varying times and conditions as required by NFPA 101 Fire Drills, Section 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. 2. Completion date 11/2/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	

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K 712	Continued From page 11 evening shift in the 3rd quarter (Jul-Sep) 2016. This deficient practice was verified by the Facility Maintenance Director.	K 712		
K 741 SS=F	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written current Smoking Policy.This deficient practice could affect 29 of 29 residents. Smoking Regulations	K 741	1. New updated "Smoking" policy specific to Colonial Manor of Balaton to be inserted into the company policy book. 2. Completion date 11/30/2016.	11/30/16

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K 741	Continued From page 12 Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation reviewed revealed that the Facility does not have a Written Smoking Policy that is specific to Colonial Manor of Balaton. This deficient practice was verified by the Facility Maintenance Director.	K 741	3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	
K 781 SS=F	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be	K 781		11/30/16

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K 781	Continued From page 13 prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written and current Space Heater Policy.This deficient practice could affect 29 of 29 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation reviewed revealed that the Facility does not have a written Space Heater Policy that is specific to Colonial Manor of Balaton. This deficient practice was verified by the Facility Maintenance Director.	K 781	1. New updated "Space Heater" policy specific to Colonial Manor of Balaton to be inserted into the company policy book. 2. Completion date 11/30/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		11/2/16

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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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 14 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 29 of 29 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918	1. Maintenance staff will start documenting the transfer time of how long it takes the emergency generator to assume power in accordance with NFPA 110. 2. Completion date 11/2/2016. 3. Correction responsibility and monitoring to prevent a reoccurrence of the deficiency will be by the Facility Maintenance Director, Douglas Hall as supervised by Executive Director, Charles Ness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2016**

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K 918	Continued From page 15 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/02/2016, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test. The transfer time of how long it takes the emergency generator to assume power is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918		

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00982	A. BUILDING: _____ B. WING _____	C 11/03/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/18/16 through 4/21/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, complaint investigation(s) were also completed at the time of the licensing survey. An investigation of complaints #H5552012 was completed. The complaint was substantiated. Correction orders were issued at State Licensing - 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 MN Statute 144.651 Subd. 18 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state	2 000		

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2 000	Continued From page 2 statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services.	2 255		12/13/16

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2 255	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a quality assessment and assurance (QAA) committee that responded to identified resident concerns and failed to implement a plan which addressed these concerns so that resident needs were met. This practice had the potential to affect all 29 residents who reside in the facility. Findings include: During observations from 10/31/16 to 11/2/16 there was noted to be concerns with call light response times and lack of cares performed according to assessed needs and cares identified on the plan of care. During interview with R7 on 11/1/16, at 4:17 p.m., who frequently attended the Resident Council meetings, R7 stated, "They (facility staff) seem to listen to concerns brought up, write it down, and they review it at the following meeting. Nothing ever happens, like no real follow thru. They just don't act on it. They say they are going but they never do." During interview on 11/3/16, at 8:52 a.m. the social worker (SW) stated she attends resident council meetings and documents the minutes/discussions. She explained that all department managers receive a copy of the council minutes and it is the responsibility of each department manager to follow up with specific and/or widespread resident concerns. The SW confirmed that poor call light response time has been a concern expressed for awhile.	2 255	Corrected	

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2 255	Continued From page 4 When interviewed on 11/3/16, at 11:43 a.m. the director of nursing (DON) stated she receives a copy of the resident council minutes and was aware of the concerns that residents expressed related to poor call light response by staff. The DON indicated only the SW and the dietary manager attended council meetings and confirmed she had not communicated any updates to the council with their concerns related to call light response times. The Resident Council meeting minutes were reviewed for the previous 12 months and revealed continuous on-going resident complaints related to slow call light response as noted in the documentation: -11/18/15- waiting a long time for call lights. -1/12/16- concerns of waiting for call lights during a.m. and p.m. -2/11/16- call lights not answered very quickly and waiting a long time in the evening. -3/23/16- call lights are still not being answered in a timely manner. -5/24/16- some residents have to wait 45 minutes to an hour to have their call lights answered. -6/22/16- call lights are still taking a long time to be answered. -7/13/16- call lights are still not being answered in a timely manner. -10/5/16- call lights continue to have a long wait time; some stated they wait 45 minutes or more. No review of previous months minutes nor follow-up regarding call light concerns noted in any of the meeting minutes reviewed since 11/18/15. During review of the QAA meeting minutes from July 2016 it was noted there was no discussion related to the poor call light response times and the minutes lacked any evidence of concerns	2 255		

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2 255	Continued From page 5 residents receiving required cares. Although the facility was aware of ongoing staffing concerns, an action plan had not been developed nor implemented to track and/or trend the concerns identified by residents. The facility was aware of the concern at the time of the meeting and failed to develop an action plan to resolve the identified concerns and/or evaluate the care provided to residents. The QAA committee lacked evidence that an effective plan had been developed to address the ongoing concerns related to staffing and meeting resident needs. SUGGESTED METHOD OF CORRECTION: The facility could assess resident needs and develop a plan to address the lack of timely call light response, lack of following the plan of care, lack of timely toileting, lack of providing grooming needs and lack of consistent staffing levels. Audits could be performed to look for patterns of inadequate care. The director of nursing could meet with nursing staff to address the concerns and implement a plan for sustained problem solving which involved the entire nursing home staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed	2 555		12/13/16

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2 555	Continued From page 6 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.	2 555	Corrected	

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2 555	Continued From page 7 During interview on 11/3/16, at 10:16 a.m. registered nurse (RN)-B verified there was no care plan related to the use of R2's oxygen, stating, "its been missed". RN-B confirmed that an oxygen dependent resident should have it identified on the plan of care. During interview on 11/3/16, at 10:34 a.m. director of nursing (DON) stated her expectation is that a care plan would include oxygen use. The facility's policy for Care Plans-Comprehensive revised 10/2010, indicates an individualized comprehensive care plan would include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is fully developed after the comprehensive assessment. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff develop a comprehensive care plan based on the comprehensive assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		12/13/16

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2 565	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide personal cares as directed by the care plan for 6 of 10 residents (R3, R5, R6, R20, R14, R9) reviewed. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 9/8/16, identified R3 required extensive assistance with grooming. R3's care plan, last revised for grooming, on 6/24/16 identified R3 had a self care deficit with grooming and bathing related to dementia and arthritis. The care plan further identified R3 had memory loss and impaired cognition and was dependent upon staff assist for bathing and grooming. During initial observation in the dining room on 11/1/16, at 11:33 a.m. R3 was observed to have long facial hair on her chin and under her nose. The facial hair was easy to visualize during conversation. During observation on 11/2/16, at 6:57 a.m. R3 was seated in the hallway in her wheelchair by the nurses station. R3 stated she had her bath this morning; however, visible long facial hair was present. When interviewed at the time of the observation, R3 stated she did not like hair on her face, was unaware she had facial hair but indicated she would like the hair shaved. R3 stated she did not know who was supposed to shave her.	2 565	Corrected	

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2 565	Continued From page 9 During interview with the hair dresser on 11/2/16, at 7:27 a.m. she stated she did not remove facial hair nor perform fingernail grooming. She stated she frequently notices resident's with long facial hair while providing hair care at the facility. During interview on 11/2/16, at 9:33 a.m. nursing assistant (NA)-D stated staff were expected to provide facial hair grooming and nail care during resident baths. NA-D stated she had not given R3 her bath this morning but that NA-F had been assigned. NA-D verified she noted that R3 did not have her facial hair removed/shaved that morning. At 9:38 a.m. during interview with NA-F it was verified R3 had not received facial hair removal/grooming during the bath. NA-F confirmed she had not shaved R3 but should have provided the grooming as expected. R6's annual MDS assessment dated 9/8/16, identified R6 required extensive assist of two staff with all activities of daily living (ADL's) and also identified R6 free of any oral or dental concerns. R6's care plan revised care plan dated 9/21/16, identified R6 with an alteration in dental status related to the use of upper dentures. The care plan identified staff would provide oral hygiene by brushing his denture and cueing him to brush his own teeth. During initial observation of R6 on 10/31/16, at 10:39 a.m. R6 was noted to have natural teeth on his lower gum line that were missing and broken. During observation of R6 on 11/1/16 at 4:35 p.m. it was noted that multiple teeth were missing on the lower gum and that teeth were somewhat protruding from the oral cavity. There was evidence of decay at the gum line of 2 teeth in the	2 565		

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COLONIAL MANOR OF BALATON	HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115

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2 565	Continued From page 10 front of the lower gums R6's lower natural teeth were noted to be cracked , discolored and had excessive food debris. During interview with R6 on 11/2/16 at 8:11 a.m. R6 stated staff were supposed to do his oral cares but they forgot sometimes. R6 stated staff failed to complete his dental cares last evening (11/1/16) and this morning (11/2/16). R20's significant change MDS dated 8/12/16 identified R20 required extensive assist of two staff with toileting. R20's care plan dated 8/18/16, identified R20 with an alteration in bladder incontinence related to functional impairment from dementia, psychotropic drug use, pain and immobility. The care plan identified R20 had a toileting schedule to be toileted every two hours. During initial observation of R20 on 10/31/16, at 2:20 p.m. R20 was seated in her wheelchair in her room between her bathroom and room. There was noted to be a puddle of urine on the floor in the middle of room. At the time of the observation, trained medication assistant (TMA)-A was made aware of the observation and entered R20's room to assist R20. TMA stated R20 was dependent on staff and mechanical lift to toilet. During observation of cares on 11/2/16, at 6:45 a.m. R20 was observed seated in hallway by nurses station in her wheelchair with eyes closed. During observation of morning cares on 11/2/16, at 6:58 a.m. R20 was observed seated in the seated in hallway by nurses station. NA-B stated R20 was assisted out of bed at approximately 6:15 a.m. at which time she was toileted.	2 565		

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2 565	Continued From page 11 On 11/2/20 at 7:32 a.m. R20 was wheeled into dining room and placed seated at table in her wheelchair. On 11/2/16, at 9:02 a.m. R20 remained seated in the dining room at table. On 11/2/20, at 9:21 a.m. R20 remained in dining room and was observed slowly wheeling herself towards the exit door. On 11/2/16, at 9:24 a.m. R20 wheeled herself out of dining room and into hallway by nurses station. R20 utilized her hands and feet to propel the wheelchair. On 11/2/16, at 9:26 a.m. R20 was seated in her wheelchair looking at newspaper while seated in the hallway by nurse station. On 11/2/16, at 9:46 a.m. NA-D assisted R20 to the bathroom at the nurses station as the hairdresser was waiting to do R20's hair and stated staff needed to toilet R20 before her hair was fixed. R20 was toileted 3 hours and 30 minutes after her assistance with toileting when gotten up. After toileting NA-D stated R20 was moderately wet when toileted and in addition, voided some when toileted. During observations on 10/31/16, at 11:10 a.m., and again on 11/2/16, at 1:14 p.m. R5's fingernails were observed to be long, jagged with dark debris under the nail on both hands. Review of R5's Cumulative Diagnosis List dated 10/12/16, included diagnosis of diabetes mellitus. Review of R5's quarterly Minimum Data Set (MDS) assessment dated 9/19/16, indicated R5	2 565		

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2 565	Continued From page 12 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment and needing extensive assistance of one staff member with personal hygiene. Review of R5's care plan dated 9/16, identified R5 with a functional deficit in personal hygiene and required staff assistance with bathing and grooming. When interviewed on 11/2/16, at 7:15 a.m. NA-B indicated R5's nail care is completed on bath days as R5 required assistance. NA-B further included R5 had diabetes and therefore nail care was only provided by the licensed nurses. A follow-up interview with LPN-B on 11/2/16, at 7:33 a.m. confirmed R5's nail care is performed weekly by licensed staff/nurse. Review of R5's treatment record dated October 2016, included a nursing order to trim R5's fingernails weekly on bath days (Monday mornings). Review of the documentation indicated nail care had been completed on 10/31/16, but R5's nails continued to be long, jagged with notable debris on 11/2/16. During interview and observation on 11/2/16, at 1:17 p.m. with NA-B, it was confirmed R5's fingernails were long, jagged and had dark debris under the nail. During interview on 11/3/16, at 11:40 a.m. the DON indicated she would have expected R5's nails to be trimmed by the licensed nurse per nursing orders and as needed. During initial interview and observation of R14 on 11/1/16, at 1:49 p.m. R14 was noted to have jagged fingernails with sharply cut angles. R14	2 565		

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2 565	Continued From page 13 stated, "the girl did them in a hurry". R14 indicated she did not like how they were trimmed. R14's nails were polished but heavily worn. During observation on 11/2/15, at 6:59 a.m. R14's nails remained jagged with sharply cut angles. During interview on 11/2/16, at 7:15 a.m. NA-B indicated R14's fingernails should be cleaned and trimmed on bath days. Review of R14's admission MDS dated 8/9/16, indicated R14 had a BIMS score of 4 indicating severe cognitive impairment and requiring extensive assistance of 1 staff with personal hygiene needs. 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. Review of R14's Bath Report dated 10/28/16, did not indicate whether the residents fingernails had been trimmed. During interview on 11/3/16, at 11:40 a.m. the DON indicated she would have expected R14's fingernails to be trimmed per resident's liking on 10/28/16, and as needed as directed on the plan of care. The facility's policy titled Care of Fingernails/Toenails revised 10/2010, indicates nail care includes daily cleaning and regular trimming. It directs to remove dirt from around and under each nail with an orange stick, trim fingernails in an oval shape, and to smooth the nails with a nail file or emery board.	2 565		

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2 565	Continued From page 14 R9's quarterly MDS dated 8/25/16, indicated severe cognitive impairment per staff interview, required total assistance of two staff for transfers and was always incontinent of bowel and bladder. Review of R9's care plan updated 8/27/16, instructed nursing to check and change for urinary incontinence every 2 hours and transfer with the use of a Hoyer (mechanical device used to lift) and two staff. During interview on 11/1/16, at 5:35 p.m. NA-A states R9 gets up on a commode using a stand lift (a mechanical standing device) before supper but after that is transferred using a Hoyer lift and and requires only check and change of incontinent briefs. During interview on 11/2/16, at 1:30 p.m. NA-F stated R9 is placed on a commode after breakfast using the Stand lift and two assist. During interview on 11/2/16, at 1:39 p.m. NA-B indicated R9 is toileted on commode with a Stand lift once/day shift. During interview on 11/3/16, at 8:17 a.m. NA-I stated R9 transfers with a Stand lift to the commode before and after every meal. NA-I stated a Stand lift had been utilized with morning cares and R9 had been assisted to the commode prior to the breakfast meal. NA-I then verified this information per R9's restorative charting record and the care list. During interview on 11/3/16, at 10:50 a.m. RN-B stated R9 is to be transferred with a Hoyer lift and is checked and changed every 2 hours for incontinence care. RN-B verified this change had occurred on 8/27/16 per the care plan as sitting	2 565		

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2 565	Continued From page 15 on a commode had been upsetting for R9. RN-B confirmed the staff care list and restorative charting record did not have the correct information communicated from the current care plan and NA's were not following care plan related to transfers and toileting. When interviewed on 11/3/16, at 11:15 a.m. the DON verified staff had incorrect information and had not been following the plan of care as directed. The DON confirmed she would expect the restorative sheet and care lists used by NA's to be accurate per R9's care plan. The facility's policy for Care Plans-Comprehensive revised 10/2010, indicates care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. Care plans could be reviewed to ensure they are accurate and communicated to the direct staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient	2 800		12/13/16

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2 800	Continued From page 16 number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure sufficient staffing was available to meet resident needs related to appropriate grooming, oral care, timely toileting and timely call light response for 8 of 29 residents (R3, R5, R6,R9, R14, R20, R29, R31). This had the potential to affect all 29 residents in the facility. Findings include: Based on observation, interview and document review the facility failed to promptly respond to call light requests and/or speak in a respectful manner for 3 of 3 residents (R6, R31, R29) who identified staff did not provide dignified care. Refer to F241. Based on document review and interview the facility failed to communicate actions taken related to the ongoing complaints of delayed call light response time expressed by the resident group over the past 12 months. This has the potential to affect all 29 residents who reside in the facility. Refer to F244. Based on observation, interview and document review the facility failed to provide personal cares as directed by the care plan for 6 of 10 residents (R3, R5, R6, R20, R14, R9) reviewed. Refer to	2 800	Corrected	

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2 800	Continued From page 17 F282. Based on observation, interview and document review the facility failed to provide grooming cares for 5 of 10 residents (R3, R6, R20, R5, R14) reviewed who were unable to perform grooming and personal hygiene without extensive staff assistance. Refer to F312. Based on observation, interview and document review the facility failed to provide timely toileting services for 2 of 2 residents (R20, R31) reviewed who required staff assistance with toileting needs. Refer to F315 Additional Interviews: During an interview on 11/1/16, at 5:26 p.m. nursing assistant (NA)-I -stated there are only 2 NAs working from 2:00 p.m. until 4:00 p.m. to provide care for 29 residents until a 3rd NA arrived to assist. The time frame for only having 2 NAs working can vary from 2-8 hours depending on the day and whether anyone is willing to come in. NA-I indicated there is always a nurse on duty but it does take awhile to get to everyone. When interviewed on 11/2/16, at 10:14 a.m. NA-C indicated at times the facility is "staff challenged" or working short. NA-C indicated the aide staffing is normally 4 NAs and 1 restorative NA; for example, this morning there were only 3 nursing assistant on duty- 1 person on the 100 wing and 2 persons on the 200 wing. NA-C indicated this was according to the schedule. NA-C stated, "there is not enough staff for all the shifts here" and indicated short staffing occurs at least 2 x weekly. NA-C confirmed there were times that residents had urinary/incontinent episodes as a	2 800		

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2 800	Continued From page 18 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 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	2 800		

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2 800	Continued From page 19 the Nurse supervisor/Charge Nurse, as a minimum, is responsible for: Assigning work schedules and staffing to meet the needs of residents; providing direct resident care as necessary or appropriate, and other tasks and functions that may 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 CORRECTION: Twenty-one (21) days	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		12/13/16

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2 830	Continued From page 20 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess the need for and implement the use of safety measures for 1 of 1 resident (R13) who smoked independently. Findings include: R13's diagnoses list from the electronic record included: chronic obstructive pulmonary disease(COPD), hypertension (high blood pressure), unspecified cerebrovascular disease, osteoarthritis, vascular dementia and nicotine dependence. R13's most recent Minimum Data Set (MDS) assessment dated 9/9/16, indicated a 14 score on the Brief Interview of Mental Status (BIMS) indicating intact cognition. R13's activities of daily living (ADLs)-independent with eating and supervision with personal hygiene. The Resident Smoking Assessment conducted for R13, initially dated 4/30/15 and subsequent quarterly (4/30/15, 7/29/15, 10/29/15, 1/25/16, 7/25/16 and 10/20/16) assessments indicated R13 was allowed to smoke independently. The areas reviewed by the nurse on the assessment included: (1) able to verbalize safety precautions, (2) able to dispose of ashes/cigarettes safely; (3)	2 830	Corrected	

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2 830	Continued From page 21 hands are steady and physically able to hold cigarette; and (4) able to call for assistance. However, none of the assessments included review of whether or not R13 had burn marks in clothing or personal belongings. R13's care plan with a revision dated 10/21/16 listed a goal: will continue to remain safe with her smoking through next review. Interventions included: (1.) Nurses-assess for smoking safety quarterly and as needed (PRN). (2.) Resident is currently independent - unsupervised; (3.) Nurses/Nurse Aide: Monitor for safe smoking, monitor for burn marks in clothing. The plan of care lacked any mention of a smoking apron nor any other safety approaches. During observation on 10/31/16, at 11:20 a.m. R13 was seated on a chair located outside the East entrance smoking a cigarette. R13 was wearing a multicolored fleece jacket, black knitted gloves with vinyl on the top and palm surfaces. A blue fleece blanket was covering her lap. During this observation R13's jacket was noted to have multiple burn holes of sizes ranging from pencil eraser to dime sized. The holes were more prevalent on the right side of the jacket and the edges of the holes had a melted appearance. R13 was holding her cigarette in her right gloved hand and the vinyl on the top and to the side of her index finger (between first and second fingers) had a melted appearance. The blanket on R13's lap also contained multiple burn holes of varying sizes. When interviewed on 10/31/16, at 11:25 a.m. R13 confirmed the holes were a result of ashes blown onto her jacket and/or blanket. It was noted that it was a very windy morning on 10/31/16. In addition, she held her cigarette between her 1st	2 830		

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2 830	Continued From page 22 and 2nd fingers of her right gloved hand and agreed the vinyl was melted, but stated she had not burned herself and that she didn't smoke her cigarette that short. R13 stated she had never been offered a smoking apron nor protective cover for her clothing, but thought it would be alright. R13 further stated she had been wearing this jacket and using the same lap blanket for "years" and didn't know whether the identified holes were recent and/or "old" burn areas. When interviewed on 10/31/16, at 1:05 p.m. the director of nursing (DON) indicated she was aware of R13's smoking habits and confirmed she had been wearing the same jacket and using the same blanket in her wheelchair "for years". The DON verified she was not aware of the burn marks located on the jacket nor the blanket. The DON confirmed she was unaware whether a smoking apron had been offered and/or had been available for R13's use. During interview on 10/31/16, at 2:04 p.m. licensed practical nurse (LPN)-C stated she has seen "a couple" of burn holes, but nothing major and not aware of anything new. LPN-C indicated R13 usually goes out to smoke 2-3 times/dayshift and was able to go outside to smoke independently. During an interview on 10/31/16, at 2:08 p.m. LPN-A indicated she had completed R13's quarterly smoking assessments and reported she was note aware of burn holes in R13's clothing and/or blanket, LPN-A stated that when the most recent assessment dated 10/21/16, was conducted she could not recall whether R13 was wearing her jacket and/or using her lap blanket. LPN-A indicated she had never received reports of ashes nor burns on R13's clothing. LPN-A	2 830		

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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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23 further stated she had not seen R13 wear gloves while smoking. LPN-A provided the Resident Smoking assessment document which indicated R13 had been assessed for independent smoking. However, R13 had not been assessed whether she had burn marks in clothing or personal belongs. LPN-A confirmed she had never assessed R13 related to this issue. When interviewed on 10/31/16, at 2:17 p.m. nursing assistant (NA)-H and trained medication aide (TMA)-B both agreed that R13 normally smokes independently and neither staff were aware of any burn marks on R13's jacket or blanket. 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. During subsequent interview with the DON on 11/2/16, at 11:15 a.m. it was confirmed R13 just been re-evaluated for safe smoking on 10/31/16 (after survey entrance). The DON reviewed the smoking assessment and confirmed the complete assessment should have included whether there was evidence of burn marks in clothing/personal belongings to ensure ongoing safety. In a subsequent interview on 11/03/16, at 9:16 a.m. the DON confirmed the care plan did not include interventions related to the use of a smoking apron, assessment of clothing, blanket	2 830		

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2 830	Continued From page 24 and/or additional personal items worn/utilized while smoking for burn marks. She confirmed she would expect this to be completed. No policy or procedure addressing resident smoking was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could reassess residents who smoke and ensure that clothing is properly assessed as part of the ability to smoke independently. An audit could be completed to ensure the assessment is complete and accurate after staff has been inserviced about appropriate supervision of smoking residents. Findings could be reviewed at quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming cares for 2 of 2 residents (R3, R20) reviewed who were unable to perform shaving and personal hygiene	2 850	Corrected	12/13/16

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2 850	Continued From page 25 without extensive staff assistance. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 9/8/16, identified R3 with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognition impairment and also identified R3 required extensive assistance of staff with grooming. R3's care plan, last revised for grooming, on 6/24/16, identified that R3 had a self care deficit with grooming and bathing related to dementia and arthritis and was dependent upon staff assistance with bathing and grooming needs. The care plan further identified R3 had memory loss and impaired cognition. During initial observation in the dining room on 11/1/16, at 11:33 a.m. R3 was observed to have long facial hair on her chin and under her nose. The facial hair was easy to visualize during conversation. During observation on 11/2/16, at 6:57 a.m. R3 was seated in the hallway in her wheelchair by the nurses station. R3 stated she had her bath this morning; however, visible long facial hair was present. When interviewed at the time of the observation, R3 stated she did not like hair on her face, was unaware she had facial hair but indicated she would like the hair shaved. R3 stated she did not know who was supposed to shave her. During interview with the hair dresser on 11/2/16, at 7:27 a.m. she stated she did not remove facial hair nor perform fingernail grooming. She stated she frequently notices resident's with long facial	2 850		

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2 850	Continued From page 26 hair while providing hair care at the facility. During interview on 11/2/16, at 9:33 a.m. nursing assistant (NA)-D stated staff were expected to provide facial hair grooming and nail care during resident baths. NA-D stated she had not given R3 her bath this morning but that NA-F had been assigned. NA-D verified she noted that R3 did not have her facial hair removed/shaved that morning. At 9:38 a.m. during interview with NA-F it was verified R3 had not received facial hair removal/grooming during the bath. NA-F confirmed she had not shaved R3 but should have provided the grooming as expected. During observation of cares on 11/1/16, at 4:06 p.m. R20 was located in her wheelchair adjacent to the nurses' station. R20 was noted to have long facial hairs on her chin and sides of face which was visible during interaction with the resident. During observation of cares on 11/2/16, at 6:58 a.m. R20 was observed seated in her wheelchair nearby the nurses station and long facial hairs were visible during interaction with the resident. During interviews with NA-C and NA-F at 11/2/16, at 12:47 p.m. staff were questioned about the presence of R20's facial hair. Both NA's stated R20 had a bath the morning of 10/31/16 and the facial hairs should have been hair clipped during the bath. Both staff confirmed it had not been done. During interview with the director of nursing (DON) on 11/2/16, at 2:00 p.m. it was verified staff should provide shaving services to all resident's on bath days as needed.	2 850		

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2 850	Continued From page 27 The facility policy for "Shaving the Resident", revised 10/2010, identified the purpose of the policy was to promote cleanliness and to provide clean skin care and identified: 1. Review resident's care plan to assess for any special needs of the resident. 2. Assemble equipment and supplies as needed. The policy did not include directions for when to shave residents or how to shave female residents, but just included basic guidelines for shaving. No other policy for shaving was submitted by facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff on performing activities of daily living (such as shaving) for residents. Also the director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to provide the proper grooming for 2 of 2 residents (R5, R14) reviewed	2 860	Corrected	12/13/16

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2 860	Continued From page 28 who were dependent upon staff for nail care. Findings include: During observation on 10/31/16, at 11:10 a.m., and again on 11/2/16, at 1:14 p.m. R5's fingernails were observed to be long, jagged with dark debris under the nail on both hands. Review of R5's Cumulative Diagnosis List dated 10/12/16, included diagnosis of diabetes mellitus. Review of R5's quarterly Minimum Data Set (MDS) assessment dated 9/19/16, indicated R5 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment and needing extensive assistance of one staff member with personal hygiene. Review of R5's care plan dated 9/16, identified R5 with a functional deficit in personal hygiene and required staff assistance with bathing and grooming. During interview on 11/2/16, at 7:15 a.m. NA-B indicated nail care for R5 is completed on bath days and R5 required assistance. NA-B further included R5 had diabetes and therefore nail care was only provided by the licensed nurses. Follow-up interview with licensed practical nurse (LPN)-B on 11/2/16, at 7:33 a.m. confirmed R5's nail care is done weekly by the licensed nurse. Review of R5's treatment record dated October 2016, included a nursing order to trim R5's fingernails weekly on bath days (Monday mornings). Review of the documentation indicated nail care had been completed on 10/31/16; however, R5's nails remained long and jagged with notable debris on 11/2/16.	2 860		

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2 860	Continued From page 29 During interview and observation on 11/2/16, at 1:17 p.m. with NA-B, confirmed R5's fingernails were long, jagged and had dark debris under the nail. During interview with the DON on 11/3/16, at 11:40 a.m. it was indicated she expected R5's nails to be trimmed by the licensed nurse per nursing orders and as needed. During initial interview and observation of R14 on 11/1/16, at 1:49 p.m. R14 was observed to have jagged finger nails with sharply cut angles. R14 stated, "the girl did them in a hurry". R14 indicated she did not like how they were trimmed. R14's nails were polished but heavily worn. During observation on 11/2/15, at 6:59 a.m. R14's nails remained jagged with sharply cut angles. Review of R14's admission MDS dated 8/9/16, indicated R14 had a BIMS score of 4 indicating severe cognitive impairment and requiring extensive assistance of 1 staff with personal hygiene needs. Review of R14's care plan dated 9/21/16, directed NA to do nail care weekly on bath days (Friday morning) and required extensive assistance of 1 staff with grooming. Review of R14's Bath Report dated 10/28/16, did not indicate whether the residents fingernails had been trimmed. During interview on 11/2/16, at 7:15 a.m. NA-B indicated R14's fingernails should be cleaned and trimmed on bath days. During interview on 11/3/16, at 11:40 a.m. the	2 860		

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2 860	Continued From page 30 DON indicated she would have expected R14's fingernails to be trimmed per residents liking on 10/28/16, and as needed. The facility's policy titled Care of Fingernails/Toenails revised 10/2010, indicates nail care includes daily cleaning and regular trimming. It directs to remove dirt from around and under each nail with an orange stick, trim fingernails in an oval shape, and to smooth the nails with a nail file or emery board. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop systems to ensure dependent residents receive the assistance needed for their cares. The DON or her designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one(21) days.	2 860		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to	2 910		12/13/16

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2 910	Continued From page 31 prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting services for 2 of 2 residents (R20, R31) reviewed who required staff assistance with toileting needs. Findings include: R20's significant change Minimum Data Set (MDS) assessment dated 8/12/16, identified R20 required extensive assist of two staff with toileting. The MDS further identified R20 was frequently incontinent of urine and did not have a toileting program and identified there had been a previous toileting plan which demonstrated R20 had reduced incontinence with the implemented plan. R20's bladder assessment (3 day toileting log from 8/13/16-8/15/16) identified R20 was able to identify the need to void and was able to void in toilet when toileted every two hour. Even though on some occasions R20 was incontinent of urine at times of toileting,(documented-small amount), R20 was able to finish voiding when toileted. R20's care plan dated 8/18/16, identified R20 with an alteration in bladder incontinence related to functional impairment from dementia, psychotropic drug use, pain and immobility. The care plan identified R20 had a toileting schedule to be toileted every two hours.	2 910	Corrected	

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2 910	Continued From page 32 During initial observation of R20 on 10/31/16, at 2:20 p.m. R20 was seated in her wheelchair in her room and a puddle of urine was noted on the floor in the middle of room. At the time of the observation, trained medication assistant (TMA)-A was made aware of the observation and entered R20's room to assist R20. TMA-A stated R20 was dependent on staff and a mechanical lift to transfer to the toilet. TMA-A verified the urine odor and incontinence. During observation of cares on 11/1/16, at 4:06 p.m. R20 was seated in the hallway by nurses station and was noted to have a strong urine odor present when standing nearby. During observation of cares on 11/1/16, at 5:05 p.m. R20 was assisted to the toilet located near the nurses station. Nursing assistant (NA)-A (who assisted R20) verified R20 was incontinent of urine when taken into the bathroom and stated she also noted the strong urine odor present but was unsure where it was from. During observation of cares on 11/2/16, at 6:45 a.m. R20 was seated in the hallway by nurses' station in her wheelchair with eyes closed. At 6:58 a.m. R20 remained seated in the wheelchair in the same location. When interviewed at this time, NA-B stated R20 was assisted out of bed at approximately 6:15 a.m. and was toileted at that time. At 7:32 a.m. R20 was wheeled into the dining room and seated at a table. At 9:02 a.m. R20 remained seated in the dining room at the same table. At 9:21 a.m. R20 left the dining room by slowly wheeling herself toward the exit door. At 9:24 a.m. R20 wheeled herself into the hallway located by the nurses' station. At 9:26 a.m. R20 remained seated in her wheelchair looking at newspaper in the same location. The	2 910		

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2 910	Continued From page 33	2 910		

hairdresser, who was waiting to fix R20's hair, stated staff needed to toilet R20 before she arrived in the beauty shop. At 9:46 a.m. NA-D assisted R20 into the bathroom located near the nurses station. R20 was toileted 3 hours and 30 minutes (6:15 a.m. -9:46 a.m.) after she was assisted with morning cares. After toileting was provided, NA-D confirmed R20 was moderately wet when assisted and also verified R20 voided some urine while on the toilet.

When interviewed on 11/2/16, at 6:50 a.m. nursing assistant (NA)-D stated R20 had the ability to void in the toilet and sometimes remained dry when toileted on a two hour schedule.

When interviewed on 11/2/16, at 1:16 p.m. registered nurse (RN)-B verified R20 was on a two hour toilet schedule and verified staff should toilet her at a minimum of every two hours.

The quarterly MDS assessment dated 8/24/16, identified R31 with a BIMS of 15, indicating intact cognition; and minimal depression with no delusions. The MDS identified that R31 required extensive assist of 1-2 staff with all activities of daily living (ADL's) except eating. The MDS assessment indicated R31 was frequently incontinent (7 or more episodes of urinary incontinence, at least 1 episode of continent voiding).

During interview on 10/31/16, at 11:21 a.m. R31 was questioned whether staff treated him with dignity and respect and R31 responded, "no." R31 stated staff will take an excessive amounts of time to respond to call lights; at times, it took around an hour to get call light response. R6 stated he uses his call light to get assistance with

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2 910	Continued From page 34 toileting. R6 stated, "I put my call light on when I am incontinent and I have to sit in an incontinent brief for a long time. That makes me feel awful upset." R31 stated he had to wait that length of time 2-3 times/week. R31 indicated the worst timeframe's to wait for assistance were during meal times and on weekends. When interviewed on 11/2/16, at 12:53 p.m. the director of nursing (DON) about R31's call light response time and stated if she would have been told about the complaints she would have handled it. The facility provided a policy titled Urinary Continence and Incontinence- Assessment and Management. The policy identified how assessments would be conducted but did not identify staff's responsibility to ensure interventions were followed. No other policy was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for incontinence to assure they are receiving the necessary treatment/services to prevent/minimize incontinence. The DON or designee, could educate all appropriate staff on the appropriate provision of services for incontinence. The DON or designee could conduct random audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser	21325		12/13/16

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21325	Continued From page 35 Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to offer and provide dental services for 1 of 3 residents (R6) reviewed who had notable broken and decaying natural teeth. Findings include. R6's annual Minimum Data Set (MDS) assessment dated 9/8/16 identified R6 required extensive assist of two staff with all activities of daily living (ADL's). R6's annual MDS 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. Further, the MDS identified R6 free of any oral or dental concerns. During initial observation of R6 on 10/31/16, at 10:39 a.m. R6 was noted to have natural teeth on his lower gum line that were missing and/or broken. During observation of R6 on 11/1/16 at 4:35 p.m.	21325	Corrected	

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21325	Continued From page 36 R6 was observed lying in bed watching television. It was noted that R6 had multiple missing lower teeth and in addition, teeth were somewhat protruding from the oral cavity. There was evidence of dark colored areas at the gum line of the two front teeth located on the lower gums. R6's lower natural teeth were noted to be cracked, discolored and have excessive food debris coating them. On 11/1/16, at 6:22 p.m. R6 was eating the evening meal in his room and was served a bowl of soup, banana and ice cream. It was noted that R6's top dentures were stored in a denture cup located on the night stand. During interview on 11/2/16, at 8:11 a.m. R6 stated staff were supposed to do his oral cares but they forgot sometimes. R6 confirmed that staff did not complete his dental cares last evening [11/1/16] nor this morning. When interviewed on 11/2/16, at 1:16 p.m. registered nurse (RN)-B stated she was not aware of R6's dental concerns and indicated she believed she visualized R6's oral cavity when she completed the annual MDS assessment dated 9/8/16. RN-B verified the MDS identified R6 to be free of any oral/dental concerns. RN-B also confirmed R6 had not had a dentist appointment since January 2015 and was not sure whether he would desire another. On 11/2/16, at 1:30 p.m. RN-B entered R6's room with the surveyor to visualize R6's oral cavity. When observed, RN-B stated she was unaware of the cracked , broken and decayed appearing teeth. RN-B stated R6 might not have opened his mouth for her to visualize his teeth earlier. During the observation RN-B asked R6 whether he	21325		

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21325	Continued From page 37 would like have a dental appointment with the dentist. R6 shook his head "Yes" and responded, "I would like to see my dentist." The facility Dental Examination/Assessment policy, revised 2/2014, identified each resident should undergo a dental assessment prior to or within 90 days of admission. (1.) Resident should be offered dental services as needed. (2.) Dental examinations will be made by the resident's personal dentist or by the facility's consultant dentist. (3.) Records of dental care provided shall be made part of the resident's medical record. (4.) Upon conducting dental examination, a resident needing dental services will be properly referred to a dentist. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop a system to ensure that routine dental services are provided and/or scheduled upon resident request. Staff could be inserviced on the system to ensure proper communication with the on-site dental provider. An audit could be conducted and reported at the quarterly quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		12/13/16

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21375	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate disposal of a contaminated sharp for 1 of 12 residents (R22) reviewed who required blood glucose monitoring. Findings include: During observation on 11/1/16 at 5:34 p.m., licensed practical nurse (LPN)-E checked a blood glucose (BG) reading for R22. LPN-E utilized hand sanitizer, obtained the individual glucometer from the medication cart, donned gloves, appropriately cleansed the finger stick site and utilized a lancet device to obtain the necessary blood sample from R22. Immediately following the use of the disposable lancet device, LPN-E tossed the used lancet device into a garbage can located at R22's bedside. LPN-E proceeded to change her gloves and administered the prescribed dose of insulin subcutaneously (SQ) in R22's abdomen. LPN-E engaged the safety device located on the used insulin syringe and placed it into a red Sharps (container for disposal of needles/sharps) container. Upon completion of the procedure, LPN-E removed her gloves and utilized hand sanitizer. When interviewed on 11/1/16 at 5:45 p.m. LPN-E was questioned whether disposal of the lancet in the garbage receptacle was normal practice. LPN-E responded, "yes" the lancet could be disposed of in the wastebasket located in a resident's room. LPN-E stated she had been trained it was an acceptable practice to dispose the lancet in a resident's trash can rather than a designated Sharps disposal container. After contemplating the question related to a	21375	Corrected	

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21375	Continued From page 39 contaminated lancet, LPN-E reapplied gloves, removed the contaminated lancet device from R22's wastebasket and placed the device into the Sharp's container. When interviewed on 11/2/16, at 9:55 a.m. the director of nursing (DON) stated her expectation was that all contaminated sharps would be disposed of appropriately in a designated red Sharp's containers. The DON verified it was not an acceptable practice to discard any sharps device, including lancets, into a wastebasket. The facility's policy titled, Sharps Disposal with a revision date of April 2012 indicated: (2.) Contaminated sharps will be discarded into containers that are: (a.) Closable; (b.) Puncture resistant; (c.) Leakproof on sides and bottom; (d.) Labeled or color-coded in accordance with our established labeling system; and (e.) impermeable and capable of maintaining impermeability through final waste disposal. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on maintaining infection control standards related to proper disposal of contaminated lancets. The director of nursing or designee could do random audits to monitor compliance with standards of pratice TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		12/13/16

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21805	Continued From page 40 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to promptly respond to call light requests and/or speak in a respectful manner for 3 of 3 residents (R6, R31, R29) who identified staff did not provide dignified care. 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. During observation of evening cares on 11/1/16, at 6:30 p.m. R6 was observed to place his call light on. R6 was observed seated in his wheelchair beside his bed with his shirt off. At 6:40 p.m. on 11/1/16 nursing assistant (NA)-G was observed to walk down the 100 wing past R6's room and not stop to answer call light nor check with him. NA-G walked past R6's room without responding to his call light. At 6:42 p.m. licensed practical nurse (LPN)-D and NA-G were observed to walk down the 100 wing past R6's room and did not stop to check on him even though his call light continued to be activated. At 6:51 p.m. NA-B was observed to walk past R6's	21805	Corrected	

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room without checking on him even though light was still on. At 6:52 p.m. NA-B again walked past R6's room and failed to check on him. At 6:54 p.m. NA-A was observed to look down the 100 wing from the nurses station. R6's call light remained on and NA-A did not check on R6. At 6:55 p.m. LPN-D was again observed to walk by R6's room while his call light continued to 'ring' and failed to respond to R6's needs. NA-G was also noted to walk pat R6's room at the same time and did not stop to check on R6. At 6:57 p.m. trained medication assistant (TMA)-A was observed to walk down the 100 wing past R6's room, with the call light on and TMA-A did not stop to check on R6. At 7:01 p.m. while observing R6 from the hallway, it was noted he was seated in his room while located in his wheelchair beside the bed. R6 was noted to be pressing on his call light with repeated action with an angry look on his face. At 7:02 p.m. the surveyor questioned R6, asking him what he needed. R6 reported he wanted to get into bed, stating, "Where the hell is that nurse I need someone. Why the hell don't they come? I've been waiting for a while."

On 11/1/16, at 7:04 p.m. the surveyor exited the room and approached NA-G and LPN-D and asked staff if they could respond to R6's call light. During the conversation LPN-D stated, Oh great, "Mr. wonderful" in a sarcastic manner. At 7:10 p.m. LPN-D and NA-G entered R6's room and assisted him into bed. R6 waited 40 minutes from the time he activated his call light before staff queried him about his needs.

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

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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 be back. The DON verified the long wait time described was a dignity issue. The DON also stated it was hard for the staff to get all of the work done with just three staff on and it was better with 4 staff. The DON said she had frequent call- ins and has been unable to replace staff as it was hard to find staff for hire.

The quarterly MDS assessment dated 8/24/16, identified R31 with a BIMS of 15, indicating intact cognition; and minimal depression with no delusions. The MDS identified that R31 exhibited some behaviors towards others and self and required extensive assist of 1-2 staff with all activities of daily living (ADL's) except eating.

During interview on 10/31/16, at 11:21 a.m. R31 was questioned whether staff treated him with dignity and respect and R31 responded, "no." R31 explained that staff seem to always be in a rush and didn't do all of his cares. R31 stated that on the evening shift during bedtime cares, staff would tell him he did not need to brush his teeth daily. R31 stated he tells staff he wants to brush his teeth anyway and staff are resistive, as if is a burden to them. It was noted that R31 has his own natural teeth. R31 further stated he had always taken good care of his teeth which was the reason he still had his natural teeth. R31 verbalized that good oral care was important to him. R31 also stated staff seem to have a problem responding to simple tasks; for example, when he requests that staff move his fan and/or garbage can beside him. R31 described that staff get snippy or argue. R31 also stated staff will take an excessive amounts of time to respond to call lights; at times, it took around an hour to

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get call light response. R6 stated he uses his call light to get assistance with toileting. R6 stated, "I put my call light on when I am incontinent and I have to sit in an incontinent brief for a long time. That makes me feel awful upset." R31 stated he had to wait that length of time 2-3 times/week. R31 also verbalized staff tell him there are others to care for. R31 was unable to report the name of the persons involved. R31 indicated the worst timeframe's to wait for assistance were during meal times and on weekends. R31 indicated he self-transferred during long wait times for staff assistance, knowing it may be unsafe. R31 further stated the staff swear while caring for him. R31 stated this language was not directed towards him but was offensive to hear. R31 stated,"They use vulgar language to include the F word, I don't like it." R31 also stated he had been informed by staff if he didn't go to bed when they wanted he would have to sleep in his chair all night. At completion of interview R31 was asked whether he had reported any of the concerns to staff and he indicated he might have told LPN-B.

During interview with the social worker (SW) on 11/2/16, at 10:14 a.m. she stated she was not aware of any of the concerns addressed by R31. SW stated she met with R31 on a monthly basis and R31 had not voiced any of the concerns to her related to staffing and/or staff attitude but would visit with R31 to hear about his concerns. SW stated R31 would be a reliable person to interview but stated he did get confused at times.

On 11/2/16, at 12:12 p.m. SW stated R31 had been interviewed and R31 verified staff came in his room and told him they didn't have time for him to brush his teeth. R31 told the SW this occurred on day and evening shifts. The SW stated staff should treat resident's with dignity and

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this was certainly not dignified treatment. The SW also stated R31 told her when staff assist him to bed staff did not wash him. The SW also confirmed that R31 reported that although he desired daily oral care, he felt staff did not think it was necessary to brush nightly. The SW also confirmed that R31 reported that oral care was not provided that morning. The SW stated that R31 was unable to report the names of the involved staff, especially if they did not wear a name tag. The SW indicated that after discussion with R31 she reported the incidents and filed a Vulnerable Adult report immediately. The SW also confirmed R31 had expressed his dislike of staff language (cursing) used in front of him.

During interview on 11/2/16, at 12:27 p.m. LPN-B stated R31 had not approached her about any of these dignity issues. LPN-A stated he will tell staff when his call light is not answered timely but she was unaware of R31 waiting and hour to toilet or staff being rude to him.

On 11/2/16, at 12:53 p.m. the director of nursing (DON) was interviewed about R31's call light response time during and other concerns. The DON stated she had not been made aware of the concerns by the resident or staff and verified R31 was reliable but was sometimes demanding and might not recall things correctly. The DON further stated if she would have been told about the complaints she would have handled it.

R29's most recent quarterly MDS assessment dated 10/17/16, identified a BIMS score of 15/15, indicating intact cognition. The activities of daily living (ADLs) assessment identified that R29 required extensive staff assistance with dressing, toileting, personal hygiene and total dependence

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21805	Continued From page 45 upon staff for transfer. When interviewed on 11/1/16, at 1:35 p.m. R29 stated there is a long wait time for staff to assist with toileting and she remained sitting on the toilet for over an hour. During this particular incident, R29 reported she was unable to reach the call light but was able to access her phone, so called the facility to inform them she needed assistance. R29 indicated this occurred approximately 2 weeks prior and explained that after the telephone call, staff did provide her with assistance. R29 further reported the previous week, (she thought it was a Sunday) the facility was so short staffed on the weekend that multiple residents were dressed in their night clothes prior to the supper meal and were taken to the dining room dressed in this manner. R29 stated she did not think this was right and she refused to go to the dining room dressed for bed. During continuous observation on 11/2/16, from 8:22 a.m. until 9:00 a.m. (38 minutes) R29's call light was noted to be activated and sounding. R29 was seated in her wheelchair her room. R29 reported she was waiting for staff to assist her to the toilet and then into her recliner. R29 also stated this was a common occurrence to wait an extended amount of time for staff to respond to her call light. R29 further indicated in the past, she had "wet her pants" because she had to wait a long time. During a subsequent interview on 11/2/16, at 11:18 a.m. R29 was seated in the wheelchair drinking coffee and indicated there was a staff (unable to report the name) that "isn't very nice, or treats me with respect". The facility policy for "Call Lights: Answering"	21805		

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21805	Continued From page 46 dated 5/2011, identified it was the facility policy call lights would be answered in an efficient manner. Procedure: 1. All staff are responsible to answer call lights. 2. Time to answer general call light requests are not to exceed 15 minutes, when possible. 3. Time to answer an emergency call light for requests and requests for assistance in the bathroom are not to exceed two minutes, when possible. 4. Call lights should be turned off promptly when addressing the stated need in a resident room. SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of vulnerable adults and review/implement policies and procedures for assuring dignified care. The facility could provide ongoing education and training and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on document review and interview the facility failed to communicate actions taken related to the ongoing complaints of delayed call	21870	Corrected	12/13/16

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21870	Continued From page 47 light response time expressed by the resident group over the past 12 months. This has the potential to affect all 29 residents who reside in the facility. Findings include: During interview on 11/1/16, at 4:17 p.m. R7 stated facility staff don't follow through with concerns expressed at resident council meetings. R7 indicated concerns are written down by the social worker (SW), reviewed at next month's meeting but no update related to what actions are taken is provided to the council. R7 further stated staffing levels and call light response continues to be an ongoing concern, responding, "it's brought up all the time". The Resident Council meeting minutes were reviewed for the previous 12 months and revealed continuous on-going resident complaints related to slow call light response as noted in the documentation: -11/18/15- waiting a long time for call lights. -1/12/16- concerns of waiting for call lights during a.m. and p.m. -2/11/16- call lights not answered very quickly and waiting a long time in the evening. -3/23/16- call lights are still not being answered in a timely manner. -5/24/16- some residents have to wait 45 minutes to an hour to have their call lights answered. -6/22/16- call lights are still taking a long time to be answered. -7/13/16- call lights are still not being answered in a timely manner. -10/5/16- call lights continue to have a long wait time; some stated they wait 45 minutes or more. No review of previous months minutes nor follow-up regarding call light concerns noted in	21870		

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21870	Continued From page 48 any of the meeting minutes reviewed since 11/18/15. During interview on 11/3/16, at 8:52 a.m. the SW stated she attends resident council meetings and documents the minutes/discussions. She explained that all department managers receive a copy of the council minutes and it is the responsibility of each department manager to follow up with specific and/or widespread resident concerns. The SW confirmed that poor call light response time has been a concern expressed for awhile. When interviewed on 11/3/16, at 11:43 a.m. the director of nursing (DON) stated she receives a copy of the resident council minutes and was aware of the concerns that residents expressed related to poor call light response by staff. The DON indicated only the SW and the dietary manager attended council meetings and confirmed she had not communicated any updates to the council with their concerns related to call light response times. The Colonial Manor of Balaton Resident Council Policy, dated 7/1/13, indicates Resident Council can improve communication between staff and residents, serve as a source of new ideas, help identify quality of life and care issues, and help individual resident speak up in a collective voice to effect change. Staff members who assist residents in their monthly meetings include social services, dietary manager, and director or (sic) nursing. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures related to grievances and resolution of grievances to ensure	21870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00982	A. BUILDING: _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 BE 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.	21870		