DEPARTMENT OF HEALTH						DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL FE SURVEY AGENCY	ID: 26D8 Facility ID: 00982		
1. MEDICARE/MEDICAID PROVIDER           (L1)         245552           2.STATE VENDOR OR MEDICAID NO           (L2)         570014100	NO.	3. NAME AND AI (L3) COLONIAL (L4) HIGHWAY (L5) BALATON,	DDRESS OF FAC MANOR OF 14 EAST PO F	CILITY BALATO		4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint		
5. EFFECTIVE DATE CHANGE OF OW (L9) 12/01/2011 6. DATE OF SURVEY 01/14/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31		
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	<ul><li>33 (L18)</li><li>33 (L17)</li></ul>	Complianc 1. A B. Not in Con		gram	2. Technical Personnel     3. 24 Hour RN     4. 7-Day RN (Rural SN     5. Life Safety Code	7. Medical Director		
14. LTC CERTIFIED BED BREAKDOW	N			1	15. FACILITY MEETS			
18 SNF 18/19 SNF 33	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:		
Kathryn Serie, Unit	Supervisor	1	2/16/2013	(L19)	Kamala Fiske-Downing, Enforcement Specialist 03/20/2014 (L20)			
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
<ol> <li>DETERMINATION OF ELIGIBILIT</li> <li><u>X</u></li> <li>1. Facility is Eligible to Part</li> <li><u>2</u>. Facility is not Eligible</li> </ol>			IPLIANCE WITH HTS ACT:	H CIVIL		ancial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :		
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	I: (L30)		
OF PARTICIPATION <b>04/01/1991</b>	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY     00       01-Merger, Closure			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(L44)		04-Other Reason for windrawar	07-Provider Status Change 00-Active		
(L27)	B. Rescind Su	spension Date:	(L44)			00112410		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		00040			Posted 04/10	0/2014 CO.		
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	DATE				
	(L32)	01/28/2014		(L33)	DETERMINATION APP	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES	<b>CENTERS FOR MEDICARE &amp; MEDI</b>	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: 26D8
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00982

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5552

On 01/14/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 01/12/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 12/04/13 standard survey, effective 01/13/2014. Refer to the CMS 2567b for both health and life safety code.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245552

March 20, 2014

Ms. Carol Kvidt, Administrator Colonial Manor Of Balaton Highway 14 East PO Box 219 Balaton, Minnesota 56115

Dear Ms. Kvidt:

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 January 13, 2014 the above facility is certified for:

33 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 33 skilled nursing facility beds located in rooms .

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,

Kumalu Fiske Downing

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

February 7, 2014

Ms. Carol Kvidt, Administrator Colonial Manor Of Balaton Highway 14 East Po Box 219 Balaton, MN 56115

RE: Project Number S5552025

Dear Ms. Kvidt:

On December 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 12, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2013, effective January 13, 2014 and therefore remedies outlined in our letter to you dated December 16, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Kathryn Serie

Kathy Serie, Unit Supervisor Licensing and Certification Program Telephone: 507-537-7158 Fax: 507-344-2723

Enclosure

cc: Licensing and Certification File

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245552	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/14/2014
Name of Facility		Street Address, City, State, Zip Code	
COLONIAL MANOR OF BALATON		HIGHWAY 14 EAST PO BOX 21 BALATON, MN 56115	9

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	) Date	(Y4) Item	(Y5)	Date
ID Prefix	F0309	Correction Completed 01/13/2014	ID Prefix	F0356	Correction Completed 01/13/2014	ID Prefix		Correction Completed
	483.25		Reg. # 48	83.30(e)	-	Reg. # LSC		
ID Prefix Reg. # LSC			ID Prefix _ Reg. # _ LSC _		Correction Completed	Dec #		Correction Completed
Reg. #			Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #					Correction Completed			Correction Completed
Reg. #						D //		
Reviewed E	By Rev	viewed By	Date:	Signature of Su	rveyor:		Date:	
State Agen	cy H	KS/KFD	03/20/20	14		03048		01/14/2014
Reviewed E CMS RO	3y Re <sup>v</sup>	viewed By	Date:	Signature of Su	rveyor:		Date:	
Followup t	o Survey Comple 12/4/20					iencies. Was a Sum S-2567) Sent to the F		NO

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245552	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 1/12/2014
Name of Facility		Street Address, City, State, Zip Code	
COLONIAL MANOR OF BALATON		HIGHWAY 14 EAST PO BOX 21 BALATON, MN 56115	9

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

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
		(	Correction			Correction					Correction
ID Prefix			Completed 12/30/2013	ID Prefix		Completed 12/31/2013		ID Prefix			Completed 12/31/2013
-	NFPA 101				NFPA 101				NFPA 101		
LSC	K0018			LSC	K0046			LSC	K0052		
		(	Correction			Correction					Correction
ID Prefix			Completed 12/31/2013	ID Prefix		Completed		ID Prefix			Completed
Reg. #	NFPA 101			Reg. #				D			
LSC	K0144			LSC			_	LSC			
		(	Correction			Correction					Correction
ID Prefix			Completed	ID Brofiv		Completed		ID Profix			Completed
Reg. # LSC				Reg. # LSC				Reg. # LSC			
		(	Correction			Correction					Correction
		(	Completed	ID Profix		Completed		ID Profix			Completed
Reg. #											
				LSC				LSC			
ID Prefix		(	Correction Completed	ID Prefix		Correction Completed		ID Prefix			Correction Completed
Reg. #				Reg. #				D			
								LSC			
Reviewed E	By Revi	ewed	Ву	Date:	Signature of Sur	veyor:				Date:	
State Agen	cy PS/	KFD		03/20/14		030	)49				01/12/2014
Reviewed E CMS RO	3y <u> </u>	ewed	Ву	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Complet 12/10/20		:		Check for any Unco Uncorrected Defic					YES	NO

DEPARTMENT OF HEALTH A	1)       245552       (L.3)       COLONIAL MANOR OF B         TE VENDOR OR MEDICAID NO.       (L.3)       COLONIAL MANOR OF B         (L.4)       HIGHWAY 14 EAST PO B       (L.5)         FECTIVE DATE CHANGE OF OWNERSHIP       7. PROVIDER/SUPPLIER CATEGORY         (L.5)       BALATON, MN         FECTIVE DATE CHANGE OF OWNERSHIP       7. PROVIDER/SUPPLIER CATEGORY         (L.10)       01 Hospital       05 HHA         (CREDITATION STATUS:      (L.10)         naccredited       1 TJC         OA       3 Other         CC PERIOD OF CERTIFICATION       04 SNF         OM       3 Other         CC PERIOD OF CERTIFICATION       10.THE FACILITY IS CERTIFIED AS:         Om (a):				CENTERS FOR MEDICARE & MEDICAID SERVICI			
							Ι	D: 26D8
	PART	I - TO BE COMP	LETED BY T	HE STAT	E SURVEY AG	ENCY	I	Facility ID: 00982
2.STATE VENDOR OR MEDICAID NO.	0.	(L3) COLONIAL (L4) HIGHWAY	MANOR OF 14 EAST PO	BALAT		56115	<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE OF OWN (L9) 12/01/2011</li> </ol>	NERSHIP			Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC		03 SNF/NF/Distinct	07 X-Ray	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY IS	CERTIFIED AS:					
	<b>22</b> ([18])	Program Requ Compliance B	ased On:		2. Tech 3. 24 H	nical Personnel	e Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S	tor
13. Total Certified Beds		X B. Not in Compli	ance with Program			Safety Code B*	9. Beds/Room (L12)	5120
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MI	EETS		
	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELLA	TION DATE):					
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY AP	PROVAL	Date:
Wendy Buckholz	<u>z, HFE NE II</u>	01	/08/2014	(L19)	Kate John	nsTon, Enfo	orcement Speciali	<u>ist</u> 01/23/2014 (L20)
	PART II - TO	BE COMPLETED	BY HCFA RE	EGIONAI	OFFICE OR S	SINGLE STAT	<b>E AGENCY</b>	
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Part        2. Facility is not Eligible	icipate (L21)	20. COMPI RIGHT	LIANCE WITH C	IVIL	2. (		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCF/	A-1513)
	(L21)				1			
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEMI BEGINNING I		LTC AGREEME ENDING DATE		26. TERMINAT <u>VOLUNTARY</u>	TION ACTION:		L30) [ <u>ARY</u>
<b>04/01/1991</b> (L24)	(L41)		(L25)			n W/ Reimbursemer		eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involu 04-Other Reason f		OTHER	
(L27)	<ul><li>A. Suspension of</li><li>B. Rescind Susp</li></ul>		(L44)		04-Other Reason I	ior withdrawai	07-Provider 00-Active	Status Change
		D 100 D 1	(L45)					
28. TERMINATION DATE:	29	INTERMEDIARY/CAI	RRIER NO.		30. REMARKS			
	(L28)	00040		(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION OF	APPROVAL DAT	ΓE				

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUM	IAN SERVICES	<b>CENTERS FOR MEDICARE &amp; ME</b>	DICAID SERVICES
	MEDICARE/MEDICAID CERTIFICATION AND TRAN	SMITTAL	ID: 26D8
	PART I - TO BE COMPLETED BY THE STATE SURVEY	AGENCY	Facility ID: 00982
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS		

#### CCN-245552

At the time of the standard survey completed December 4, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7062

December 16, 2013

Mr. Michael Miller, Administrator Colonial Manor of Balaton Highway 14 East PO Box 219 Balaton, Minnesota 56115

RE: Project Number S5552025

Dear Mr. Miller:

On December 5, 2013, 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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 East Lyon Street Marshall, MN 56258-2529

Office: (507) 537-7158 Fax: (507) 537-7194

#### **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 January 13, 2014, 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 January 13, 2014 the following remedy will be imposed:

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

#### PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

### VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner Colonial Manor of Balaton December 16, 2013 Page 4 than the latest correction date on the PoC.

#### 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 March 5, 2014 (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 June 5, 2014 (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:

Colonial Manor of Balaton December 16, 2013 Page 5

> Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Are Klegepe

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

		AND HUMAN SERVICES				RINTED: 12/16/2 FORM APPROV	VED
1 .	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			1	<u>MB NO. 0938-03</u>	
	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					EXIT date 1	2/4/13 Per KS	
		245552	B. WING		ML	<del>12/05/201</del> 3	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST. HIGHWAY 14 EAST PO BC			
	AL MANOR OF BALA			BALATON, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPF ICIENCY)	BE COMPLET	TION
F 000	INITIAL COMMENT	-S	F 00	0			
	as your allegation c Department's acce	of correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance.				•	
F 309 SS=D	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with CARE/SERVICES FOR EING	F 30	99			
	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain lest practicable physical, social well-being, in e comprehensive assessment	суррг <sup>у</sup> Кт 12/30	ved 13			
	by: Based on observat review, the facility fa	NT is not met as evidenced ion, interview, and document ailed to maintain comfortable ng for 1 of 2 residents (R22) wed for positioning.			•		
	Findings include:						
	5:01 p.m. The resid wheelchair (w/c) with	and interviewed on 12/2/13, at dent was seated in a h a 2 1/2-3 inch deep			RECEIVE		
	eggcrate-type foam	pad on the seat. The was seated forward on			Annestoa Department o Marchall		
Any deficienc	y statement ending with	ER/SUPPLIER REPRESENTATIVE'S SIG	hich the insti	TITLE	-ve Directing providir	(X6) DAT $\gamma = \frac{12/3\rho}{12/3\rho}$	/13
following the	rds provide sufficient pro date of survey whether or	tection to the patients. (See instruction not a plan of correction is provided. I nts are made available to the facility.	ns.) Except For nursing	for nursing homes, the findi	ings stated above a and plans of correct	re disclosable 90 o tion are disclosable	days e 14

program participation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	FOR MEDICARE	& MEDICAID SERVICES	RVICES			OMB NO. 0938-039		
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245552	B. WING			<del>-12/0</del>	<del>5/2013</del>	
NAME OF PRO	OVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE	1		
COLONIAL	MANOR OF BALAT				HIGHWAY 14 EAST PO BOX 219			
COLONIAL	MANOR OF BALA	IUN			BALATON, MN 56115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
ap he th re ur w/ in w/ DI 12 he wa pa su al he su al he su al " a w/ ch ac st Re Fo ar du po wi R2 da sr e st	er back was at an he back of the chai eposition herself du nable to manage to /c with her back st terview R22 stated heelchair "a lot." uring an observati 2/4/13, at 7:57 a.m er wheelchair on th as again observed art of the chair. Th urveyor she felt "un though she tried to erself back in the c uccessfully. The re- hything that can be corning at 11:38 a.n dways" felt like she /c. She said she c hange in wheelchai dmission more tha ad never been add ated, "I guess I've ecord review revea orm, which had be nd 10/30/13, which uring each review, por positioning in v ithout assistance." 22's Minimum Dat ated 10/31/13, indi steoarthrosis and r sident's care plan	Tont two thirds of the seat, and angle rather than flush with r. R22 attempted to uring the interview, but was o sit fully on the seat of the raightened. During the d that she slid forward in her on and interview of R22 on the resident was seated in he eggcrate-type cushion. She to be seated on the forward he resident informed the nocomfortable" and stated that b use her heels to move chair, she was unable to do so esident asked, "Is there e done about that?" Later that m. R22 confirmed she e was sliding forward in her did not think she'd had a ir cushions since her n two years prior, and said it tressed by the staff. She never complained about it." aled a Resident Screening en reviewed 1/16/13, 9/26/13, n revealed answers of "no" to the problem of "Consistent vheelchair, unable to correct	F3	308				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 26D811

Facility ID: 00982

If continuation sheet Page 2 of 5



## DEC 3 0 2013

Manestoa Department of Health Marshall

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES       (X1) PROVIDERSUPPLERCLA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SUPPLY         AND PLAN OF CORRECTION       245552       B. WING       4.00LDING         NAME OF PROVIDER OR SUPPLIER       245552       B. WING       4206/2013         COLONIAL MANOR OF BALATON       STREET ADDRESS, CITY, STATE, ZIP CODE       4206/2013         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREVIX         TAGE       Continued From page 2       ID       ID       PREVIX         arthritis and the need for assistance with ambulation and some transfers.       A physical therapy assistant (PTA)-B was i			& MEDICAID SERVICES			OMB N	O. 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       COLONIAL MANOR OF BALATON     STREET ADDRESS, CITY, STATE, ZIP CODE       PREFIX     SUMMARY STATEMENT OF DEFICIENCIES     BALATON, MN 55115       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D     PROVIDERS PLAN OF CORRECTION SHOULD EL (CACS-AFFERENCED TO THE APPROPRIATE DEFICIENCY)     000000000000000000000000000000000000	STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) D	ATE SURVEY
AMME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       COLONIAL MANOR OF BALATON     HIGHWAY 14 EAST PO BOX 219       BALATON, MN 56115     BALATON, MN 56115       (X4) ID PREFIX     IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)     PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (S9) TAG       F 309     Continued From page 2 arthritis and the need for assistance with ambulation and some transfers.     F 309       A physical therapy assistant (PTA)-B was interviewed on 12/4/13, at 11:08 a.m. The PTA stated she was unaware R22 was having issues with her w/c as the resident did not offer any complaints when screened in October 2013. PTA-B observed and interviewed R22 at that time in the resident's room. The resident was observed to have difficulty repositioning herself in the w/c, and when seated upright, her feet did not fully touch the floor. R22 explained that she was more comfortable when her back touched the backrest of the w/c, but stated she always felt as if she was sitting at an angle in the chair. PTA-B confirmed the wick and so thare usitions for R22 to try. The resident tried both cushions, and one of the cushions was thinner and allowed the resident to sit upright in the wheelchair with her back fush against the chair DAB. PTA-B stated			245552	B. WING		_   _	2/05/2013
PREFIX TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Countinued DATE         F 309       Continued From page 2 arthritis and the need for assistance with ambulation and some transfers.       F 309         A physical therapy assistant (PTA)-B was interviewed on 12/4/13, at 11:08 a.m. The PTA stated she was unaware R22 was having issues with her w/c as the resident did not offer any complaints when screened in October 2013. PTA-B observed and interviewed R22 at that time in the resident's room. The resident was observed to have difficulty repositioning herself in the w/c, and when seated upright, her feet did not fully touch the floor. R22 explained that she was more comfortable when her back touched the backrest of the w/c was a poor fit for the resident, and said that either a new cushion or a shorter w/c would benefit the resident. PTA-B confirmed the w/c was a poor fit for the resident, and said that either a new cushion or a shorter w/c would benefit the resident. PTA-B returned at 11:18 a.m. with two alternative chair cushions, and one of the cushions was thinner and allowed the resident to sit upright in the wheelchair with her back flush against the chair back. PTA-B stated back new Approxement at the chair back to the back Rush against the chair back. PTA-B			TON	1	HIGHWAY 14 EAST PO BOX	TE, ZIP CODE	
A physical the need for assistance with ambulation and some transfers. A physical therapy assistant (PTA)-B was interviewed on 12/4/13, at 11:08 a.m. The PTA stated she was unavare R22 was having issues with her w/c as the resident did not offer any complaints when screened in October 2013. PTA-B observed and interviewed R22 at that time in the resident's room. The resident was observed to have difficulty repositioning herself in the w/c, and when seated upright, her feet did not fully touch the floor. R22 explained that she was more comfortable when her back touched the backrest of the w/c, but stated she always felt as if she was sitting at an angle in the chair. PTA-B confirmed the w/c was a poor fit for the resident, and said that either a new cushion or a shorter w/c would benefit the resident. PTA-B returned at 11:18 a.m. with two alternative chair cushions for R22 to try. The resident tried both cushions, and one of the cushions was thinner and allowed the resident to sit upright in the wheelchair with her back flush against the chair back, PTA-B stated	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION
<ul> <li>she would notify the occupational therapist of the need for further assessment of R22's w/c positioning.</li> <li>PTA-B was interviewed after the interaction with R22 and stated residents typically voiced concerns when their w/c positioning was uncomfortable, and because R22 had not the assistant stated, "I guess I just missed it." She did not recall whether she had observed R22 in her w/c at the time of the October 2013 screening.</li> <li>The director of nursing (DON) was interviewed on 12/4/13, at 11:35 a.m. and explained that she</li> </ul>		arthritis and the nee ambulation and sor A physical therapy a interviewed on 12/4 stated she was una with her w/c as the complaints when so PTA-B observed an in the resident's roc observed to have di the w/c, and when s fully touch the floor. more comfortable w backrest of the w/c, if she was sitting at confirmed the w/c w and said that either w/c would benefit th 11:18 a.m. with two R22 to try. The resi one of the cushions resident to sit uprigh back flush against th she would notify the need for further ass positioning. PTA-B was interview R22 and stated resi- concerns when their uncomfortable, and assistant stated, "I g did not recall whether her w/c at the time of screening. The director of nursi	ed for assistance with ne transfers. assistant (PTA)-B was /13, at 11:08 a.m. The PTA ware R22 was having issues resident did not offer any creened in October 2013. d interviewed R22 at that time m. The resident was fficulty repositioning herself in seated upright, her feet did not R22 explained that she was /hen her back touched the but stated she always felt as an angle in the chair. PTA-B /as a poor fit for the resident, a new cushion or a shorter e resident. PTA-B returned at alternative chair cushions for dent tried both cushions, and was thinner and allowed the ht in the wheelchair with her he chair back. PTA-B stated occupational therapist of the essment of R22's w/c	F3	309		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 26D811

Facility ID: 00982

If continuation sheet Page 3 of 5

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Manestoa Department of Health Marshall

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

		A MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·			OWB NO	<u>. 0938-0391</u>
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	(X3) DA COI	E SURVEY MPLETED
	· · · ·	245552	B. WING			-42	<del>/05/2013</del>
	PROVIDER OR SUPPLIER	TON	1	HIGHV	ET ADDRESS, CITY, STATE, ZIP C NAY 14 EAST PO BOX 219 NTON, MN 56115		103/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	her back was at an the back of the cha reposition herself d unable to manage w/c with her back s interview R22 state wheelchair "a lot." During an observat 12/4/13, at 7:57 a.r her wheelchair on t was again observe part of the chair. T surveyor she felt "u although she tried t herself back in the successfully. The r anything that can b morning at 11:38 a. "always" felt like sh w/c. She said she change in wheelcha admission more tha had never been ado stated, "I guess I've Record review reve Form, which had be and 10/30/13, which during each review, poor positioning in w without assistance." R22's Minimum Dar dated 10/31/13, ind osteoarthrosis and resident's care plan	ront two thirds of the seat, and angle rather than flush with ir. R22 attempted to uring the interview, but was to sit fully on the seat of the traightened. During the d that she slid forward in her ion and interview of R22 on n. the resident was seated in he eggcrate-type cushion. She d to be seated on the forward he resident informed the ncomfortable" and stated that o use her heels to move chair, she was unable to do so resident asked, "Is there e done about that?" Later that m. R22 confirmed she e was sliding forward in her did not think she'd had a air cushions since her an two years prior, and said it dressed by the staff. She e never complained about it." aled a Resident Screening een reviewed 1/16/13, 9/26/13, n revealed answers of "no" to the problem of "Consistent wheelchair, unable to correct	F 3	F30!		lluated on tioning in nion c. n MD to patient for 6 days for w/c ented by s it applies re ing room body /c on 12/6. were asked at may cult all residents on 12/7/13 ed to D.O.N. a thorough atient's r/c x1. tinue to do s on all ze all noon meal	
DRM CMS-25	67(02-99) Previous Versions		1	Facility II	D: 00982	th for If continuation s	heet Page 2

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA , IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245552	B. WING		<b>12/(</b>	<del>)5/20<b>1</b>3</del>
	PROVIDER OR SUPPLIER		ŀ	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 309	ambulation and so A physical therapy interviewed on 12/ stated she was un with her w/c as the complaints when s PTA-B observed a in the resident's ro observed to have of the w/c, and when fully touch the floo more comfortable backrest of the w/c if she was sitting a confirmed the w/c and said that eithe w/c would benefit t 11:18 a.m. with two R22 to try. The re one of the cushion resident to sit uprig back flush against she would notify th need for further as positioning. PTA-B was intervie R22 and stated re concerns when the uncomfortable, an assistant stated, "I did not recall whet her w/c at the time screening. The director of nut	eed for assistance with	F 309	<ul> <li>positioning from De through January 8, 2</li> <li>D. RN managers will in cognitive residents x identify personal conrelated to positionin w/c.</li> <li>4. Corrective Action Mont A. Effectiveness of aud both PT/OT and RN be evaluated by IDT and the Quality Asse Committee on Jan. 2014.</li> <li>5. Completion Date: <ul> <li>A. Completion date wi January 16<sup>th</sup> 2014.</li> </ul> </li> </ul>	014. tterview 1 to ncerns g in itoring: its by s will `weekly urance 16 <sup>th</sup> ,	2 mines to

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		AND HUMAN SERVICES & MEDICATÓ SERVICES			-+	FORM A	
TATEMENT OF DEFICI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMF	PLETED
		245552	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE		5/2013
NAME OF PROVIDER		TON		н	GHWAY 14 EAST PO BOX 219 ALATON, MN 56115		
PREFIX (EAC	CH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
position poorly p DON co R22's p	ed residents ing, and ide positioned d onfirmed sh positioning, a pave verbali	age 3 in the dining room for proper entified residents who were uring those observations. The e had not noticed issues with and added that typically R22 zed her concerns to staff but		309			
SS=C INFOR The fac a daily o Facili o The c o The t by the f unlicen resider - R - Li vocatio - C o Resid The fac specific of each o Clea o In a p resider The fac standa	MATION sility must per basis: ty name. current date otal number following ca sed nursing at care per s egistered nurses ertified nurses ertified nurses dent census clility must p ed above or a shift. Data r and reada prominent p nts and visit cility must, m nurse staffin iew at a cos ird.	r and the actual hours worked tegories of licensed and staff directly responsible for shift: urses. ctical nurses or licensed (as defined under State law). se aides. 5. ost the nurse staffing data in a daily basis at the beginning a must be posted as follows: ble format. Jace readily accessible to	y e	356	<ul> <li>F 356</li> <li>1. Corrective Action <ul> <li>A. Posted new form fastaffing hours per Guidelines.</li> </ul> </li> <li>2. Corrective action for all residents: <ul> <li>A. Nursing Shifts ind for calculation of hours.</li> </ul> </li> <li>3. System Change: <ul> <li>A. Charge nurses in on proper use of shours form on De</li> </ul> </li> <li>4. Corrective Action Mort A. DON will monitor form and data entries x1 mo</li> <li>5. Date of Completion: <ul> <li>A. January 16<sup>th</sup>, 2014.</li> <li><i>Y</i></li> </ul> </li> </ul>	CMS Il licated nursing structed staffing sc.7 <sup>th</sup> 2013 litoring: daily nth	traton in al

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

PRINTED:	12/16/2013
FORM	APPROVED
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		& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		0	<u>MR NO.</u>	0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245552	B. WING	;		<del>- 12/05/2013</del>	
NAME OF	PROVIDER OR SUPPLIER	L	L		STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	5572015
	AL MANOR OF BALA	TON			HIGHWAY 14 EAST PO BOX 219		
					BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 356	Continued From pa required by State Ia	ge 4 w, whichever is greater.	F	35	6		
	by: Based on observat review, the facility fa hours accurately ide nursing personnel a potential to affect al visitors. Findings include: Posted nursing hou initial tour of the fac Although the posting specific personnel a worke, the posting f shifts worked. Durin on 12/3/13, the infor same manner, with shifts worked for ea The postings for 11/ were reviewed. Eac the numbers of regi practical nurses, tra nursing assistants s total number of hou however there were indicate who was wo	0					
	12/4/13, at 8:00 a.m. staffing hours in the	ing stated in an interview on a. the facility had posted same format "for awhile", was unaware the posting was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 26D811

Facility ID: 00982

If continuation sheet Page 5 of 5



Manestoa Department of Health Marchall

STATEMEN	ATEMENT OF DE FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY
		245552	B, WING		1	
NAME OF	PROVICER OR SUPPLIEF	R	-L.,	STREET ADDRESS, CITY, STATE, ZIP CO	1 1.2J	10/2013
COLON	AL MANOR OF BAL	ATON		HIGHWAY 14 EAST PO BOX 218		
				BALATON, MN 56115		
(X4) ID PREFIX TAG	I CACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
K 000	INITIAL COMMEN	ΤS	KO	00		
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.		POCOK 1-8-14		
	CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.		(Y)		
F	Fire Marshal Division Fire Marshal Division the time of this surve was found not to be with the requirement Medicare/Medicaid 483.70 (a), Life Safe edition of National F	Survey was conducted by the ent of Public Safety, State on, on December 10, 2013. At ey, Colonial Manor of Balaton in substantial compliance ts for participation in at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association ety Code (LSC), Chapter 19 e Occupancies.		<b>RECEIV</b> JAN - 3 20 MN DEPT. OF PUBLIC STATE FIRE MARSHAL	14	
	DEFIC ENCIES (K-7	R THE FIRE SAFETY FAGS) TO:		E STATE THE WARDNAL		
4	Health Care Fire Ins State Fire Marshal D 145 Minnesota Stree St. Paul, MN 55101-	Division At, Suite 145		RECENT DEC 30		
		1		Astuncatoa Depinitmen		

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 su vay whether or not a plan of correction is provided. For nursing homes, the above findings and plane 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.

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/16/2013 APPROVED
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE	0938-0391 E SURVEY PLETED
		245552	B. WING _		12/	10/2013
	PROVIDER OR SUPPLIER	τον		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115	1 127	
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 018 SS=D	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurrent Colonial Manor of B 1973, is one-story in fully fire sprinkler pro to be of Type II(111) The facility has a fire detection in the corr corridors which is m department notificat capacity of 33 beds time of the survey. The requirement at 4 NOT MET as eviden NFPA 101 LIFE SAF Doors protecting cor required enclosures hazardous areas are those constructed of wood, or capable of	tate.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE RMATION: what has been, or will be, done ency. posed, completion date. title of the person ection and monitoring to nce of the deficiency. alaton was constructed in a height, has no basement, is protected and was determined construction. e alarm system with smoke idors and spaces open to the onitored for automatic fire ion. The facility has a and had a census of 32 at 42 CFR, Subpart 483.70(a) is	К 018	0		

Facility ID: 00982

If continuation sheet Page 2 of 6

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

PRINTED: 12/16/2013 FORM APPROVED

STATELMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245552       B. WING       12/10/2013         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       12/10/2013         COLONIAL MANOR OF BALATON       STREET ADDRESS, CITY, STATE, ZIP CODE       HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE       (X5) COMPLETED	CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, GTV, STATE, 2P CODE       COLONIAL MANOR OF BALATON     STREET ADDRESS, GTV, STATE, 2P CODE       MAY     SUMMARY STATEMENT OF DEPICENCIES       TAG     Continued From page 2       required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suble for keeping the door closed. Dutch doors meeting 19.3.6.3.6       are permitted.     19.3.6.3       Roller latches are prohibited by CMS regulations in all health care facilities.       This STANDARD is not met as evidenced by: Based on observation, a corridor door was not equipped with positive latching hardware. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19. Section 19.3.6.3       FINDINGS INCLUDE: On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room #314 was not equipped with door latching hardware, and did not positively latch into its frame.       This finding was verified with the facility administration at the time of discovery.       K 046 SSEE       K 046 SSEE	AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA ( IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION		(X3) DATE	E SURVEY	
NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, GTV, STATE, 2P CODE       COLONIAL MANOR OF BALATON     STREET ADDRESS, GTV, STATE, 2P CODE       MAY     SUMMARY STATEMENT OF DEPICENCIES       TAG     Continued From page 2       required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suble for keeping the door closed. Dutch doors meeting 19.3.6.3.6       are permitted.     19.3.6.3       Roller latches are prohibited by CMS regulations in all health care facilities.       This STANDARD is not met as evidenced by: Based on observation, a corridor door was not equipped with positive latching hardware. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19. Section 19.3.6.3       FINDINGS INCLUDE: On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room #314 was not equipped with door latching hardware, and did not positively latch into its frame.       This finding was verified with the facility administration at the time of discovery.       K 046 SSEE       K 046 SSEE				B, WING	;		12/	14010040	
COLONIAL MANOR OF BALATON     HIGHWAY 14 EAST PO BOX 219 BALATON, NN 56115       Colspan="2">BALATON, NN 56115       OVER THE ORDER TO FORE PERCENCE BY FULL REGULTION FOR LGO DENTIFYING INFORMATION)     PREFIX     PREFIX     PREFIX     Conducts PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GE CRUSS REFERENCE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GE CRUSS REFERENCE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GE CRUSS REFERENCE TO THE APROPRIATE DENTIFYING INFORMATION)     DIPONDERS PEAN OF CORRECTIVE ACTION TO THE APROPRIATE DENTIFYING INFORMATION TO THE APPONENT INFORMATION TO THE APPONENT DENTIFYING INFORMATION TO THE APPONENT INFORMATION TO THE APPONENT DENTIFYING INFORMATION TO THE APPONENT INFORMATION TO THE APPONENT DENTIFYING INFORMATION TO THE APPONENT INFORMAT	NAME OF	PROVIDER OR SUPPLIER		L	S	STREET ADDRESS, CITY, STATE, ZIP CODE	141	10/2015	
CALATON, NM 56115       DYI ID PREFIX TAG     SUMARY STATEMENT to DEFIVIENCES (CACH DERIVENY MET REPRETEDED BY FULL REGULATORY OR LSC IDENTIFYING NFORMATCON)     D PREFX TAG     PROVIDER PLAN OF CORRECTION (CACH DERIVENY OR THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING NFORMATCON)     D PREFX TAG     PROVIDER PLAN OF CORRECTION (CACH DERIVENY ALTION SHOULD BE CROSS NET PREMEMENT ON THE APPROPRIATE DEFIDENCY)     OWNED THE APPROPRIATE DEFIDENCY)     OWNED THE APPROPRIATE DEFIDENCY)       K 018     Continued From page 2 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19: 3.6.3.6 are permitted. 19: 3.6.3     K 018     I. Corrective Action: A. Maintenance staff replaced deadoolt locking mechanism on the break room door with astandard door knob with spring latch door knob with spring latch door knob with spring latch B. The completion date was December 30, 2013. C. The maintenance and Roger Wendiand as supervised by executive director Charles Ness was responsible for the repair.       FINDINGS INCLUDE: On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room 4314 was not equipped with door latching hardware, and did not positively latch into its frame. This finding was verified with the facility administrator at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is     K 046	COLONI	AL MANOR OF BAL	ATON						
PREFX       TAG       REGULTION OR LISCIDENTIFYING INFORMATION)       PRECV       PRECV </td <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		1							
<ul> <li>For the provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</li> <li>Roller latches are prohibited by CMS regulations in all health care facilities.</li> <li>This STANDARD is not met as evidenced by: Based on observation, a corridor door was not equipped with positive latching hardware. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.5.3. In a fire emergency, this deficient practice could adversely affect 18 of 33 residents, staff and visitors.</li> <li>FINDINGS INCLUDE:</li> <li>On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room #314 was not equipped with door latching hardware, and did not positively latch into its frame. This finding was verified with the facility administrator at the time of discovery.</li> <li>K 046</li> <li>K 046</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE	
Image: Instant State in the construction of the constru	K 018		age 2	KC	018				
<ul> <li>A Dimpediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</li> <li>Roller latches are prohibited by CMS regulations in all health care facilities.</li> <li>This STANDARD is not met as evidenced by: Based on observation, a corridor door was not equipped with positive latching hardware. This deficient practice could adversely affect 18 of 33 residents, staff and visitors.</li> <li>FINDINGS INCLUDE:</li> <li>On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room #314 was not equipped with door latching hardware, and did not positively latch into its frame.</li> <li>K 046</li> <li>K 046</li> </ul>	/	required to resist th	he passage of smoke There is		1.2				
<ul> <li>I. Corrective Action:</li> <li>A. Maintenance staff replaced deadbolt locking mechanism on the break room door with a standard door knob with spring latch.</li> <li>This STANDARD is not met as evidenced by: Based on observation, a corridor door was not equipped with positive latching hardware. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 18 of 33 residents, staff and visitors.</li> <li>FINDINGS INCLUDE:</li> <li>On 12/10/2013 at 2:10 PM, observation revealed the corridor door latching hardware, and did not positively latch into its frame.</li> <li>This finding was verified with the facility administrator at the time of discovery.</li> <li>K 046</li> <li>SSEE</li> </ul>		no impediment to t	the closing of the doors Doors		1	K 018			
<ul> <li>A. Maintenance staff replaced deadbolt locking mechanism on the break room door with a standard door knob with spring latch.</li> <li>B. This STANDARD is not met as evidenced by: Based on observation, a corridor door was not equipped with positive latching hardware. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 18 of 33 residents, staff and visitors.</li> <li>FINDINGS INCLUDE:</li> <li>On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room #314 was not equipped with door latching hardware, and did not positively latch into its frame.</li> <li>This finding was verified with the facility administrator at the time of discovery.</li> <li>K 046</li> <li>K 046</li> </ul>	/	the door closed. D	Means suitable for keeping		1	- A dian			
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<ul> <li>In all health care facilities.</li> <li>In all health care facility administrator at the time of discovery.</li> <li>In all health care facility administrator at the time of discovery.</li> <li>In all health care facility administrator at the tare of discovery.</li> <li>In all health care facility administrator at the tare of discovery.</li></ul>	7				1		placeu		
K 046         K 047         K 048         K 049         K 046		in all health care fa	prohibited by CMS regulations		1	Ū.	le		
K 046			an den realth care facilities.						
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equipped with positive latching hardware. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 18 of 33 residents, staff and visitors.       FINDINGS INCLUDE:         On 12/10/2013 at 2:10 PM, observation revealed the corridor door to Staff Break Room #314 was not equipped with door latching hardware, and did not positively latch into its frame.       This finding was verified with the facility administrator at the time of discovery.         K 046       NFPA 101 LIFE SAFETY CODE STANDARD       K 046	1	This STANDARD	s not met as evidenced by:		J	1			
K 046         SS=E         K 046         SS=E         RM CMS-2567/02-99) Previous Versions Observation	1	equipped with posit	tive latching hardware This		J	responsible for the r	epair.		
Requirements at NFPA 101 (2000) Chapter 19,         Section 19.3.6.3. In a fire emergency, this         deficient practice could adversely affect 18 of 33         residents, staff and visitors.         FINDINGS INCLUDE:         On 12/10/2013 at 2:10 PM, observation revealed         the corridor door to Staff Break Room #314 was         not equipped with door latching hardware, and did         not positively latch into its frame.         This finding was verified with the facility         administrator at the time of discovery.         NFPA 101 LIFE SAFETY CODE STANDARD         K 046         SS=E         RM CMS-2567(02-99) Previous Versions Obselete	1	deficient practice w	vas not in accordance with the		1		•	i	
K 046       NFPA 101 LIFE SAFETY CODE STANDARD       K 046         RM CMS-2567(02-99) Previous Versions Obsolute       Denote the control of the co		requirements at NF	-PA 101 (2000) Chapter 19		1				
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K 046         SS=E         RM CMS-2567(02-99) Previous Versions Observation         RM CMS-2567(02-99) Previous Versions Observation		residents, staff and	visitors.		1				
K 046       SS=E         RM CMS-2567(02-99) Previous Versions Obsolete       Exercicle sectors of the sectors		FINDINGS INCLUE	DE:						
K 046       SS=E         RM CMS-2567(02-99) Previous Versions Obsolete       Exercicle sectors of the sectors		On 12/10/2013 at 2		1	]				
K 046       NFPA 101 LIFE SAFETY CODE STANDARD       K 046         SS=E       Emergency lighting of at least 1½ hour duration is       K 046		the corridor door to	) Staff Break Room #314 was						
Administrator at the time of discovery.         K 046         SS=E         Rmergency lighting of at least 1½ hour duration is         RM CMS-2567(02-99) Previous Versions Obsolete		not equipped with d	door latching hardware, and did						
K 046       NFPA 101 LIFE SAFETY CODE STANDARD       K 046         SS=E       Emergency lighting of at least 1½ hour duration is       K 046         RM CMS-2567(02-99) Previous Versions Obsolete       Exact /P oppositions of a section of the opposition of the op		This finding was ve	rified with the facility						
Emergency lighting of at least 1½ hour duration is	K 046	NFPA 101 LIFE SA	FETY CODE STANDARD	КО	J46				
RM CMS-2567(02-99) Previous Versions Obsolete Event ID: 26D821 Facility ID: 00982 If continuation sheet Page		Emergency lighting	of at least 1½ hour duration is	l					
n vontinuation should age	DRM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 26D821	<u> </u>	Fac	cility ID: 00982 If conti	nuation sh	eet Page 3	

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		AND HUMAN SERVICES			FORM	12/16/2013 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA * IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245552	B. WING		12/	10/2013
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 046 K 052 SS=F	provided in accorda This STANDARD i Based on a review facility could not do emergency lights h each month of the practice was not in requirements at NF Section 19.2.9.1 ar a fire or other emer could adversely affi and visitors. FINDINGS INCLUE On 12/10/2013 at 1 available records p administrator, no do provided verifying t emergency lights h months of August, November of 2013. NFPA 101 LIFE SA A fire alarm system installed, tested, ar with NFPA 70 Natio 72. The system has	ance with 7.9, 19.2.9.1, s not met as evidenced by: of available records, the cument that battery-operated ad been inspected/tested in prior year. This deficient accordance with the PA 101 (2000), Chapter 19, nd Chapter 7, Section 7.9.3. In gency, this deficient practice ect 33 of 33 residents, staff DE: 2:40 PM, during a review of rovided by the facility ocumentation could be hat battery-operated ad been tested during the September, October and FETY CODE STANDARD n required for life safety is nd maintained in accordance onal Electrical Code and NFPA s an approved maintenance n complying with applicable	κo	<ul> <li>K 046</li> <li>Corrective Action: <ul> <li>A. Maintenance staff resume testing, and documentation of testing, of the bate operated emerger</li> <li>B. The resumption of December 31, 20</li> <li>C. The maintenance</li> <li>Roger Wendland supervised by exadirector Charles I be responsible for testing.</li> </ul> </li> </ul>	nd The tery ncy light of testing 13. man as ecutive Ness wil	5 is
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Event ID: 26D821

Facility ID: 00982

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		AND HUMAN SERVICES			FORM	12/16/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA * IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245552	B. WING		12/	10/2013
	PROVIDER OR SUPPLIER	TON		STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 052	Continued From pa	ge 4	K 0	52 K 052	1	1
K 144 SS=F	Based upon a revie of the digital alarm (DACT) had not be month of the previc practice was not in requirements at NF Section 9.6.1.4, and 72 (1999) and CMS could adversely affe and visitors. FINDINGS INCLUE On 12/10/2013 at 1 available records pr administrator, no do provided verifying the transmitter (DACT) of August, Septemb 2013. NFPA 101 LIFE SA	2:10 PM, during a review of rovided by the facility ocumentation could be he digital alarm communicator was tested during the months per, October and November of FETY CODE STANDARD pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	К 1	<ul> <li>3. Corrective Action:</li> <li>A. Maintenance staresume testing, a documentation of testing, of fire a alarm community transmitter.</li> <li>B. The proposed resting is Decemponent 2013.</li> <li>C. The maintenance Roger Wendlam supervised by early director Charles be responsible for testing.</li> </ul>	and of the arm digital cator sumption o ber 31, e man tas cecutive Ness will	_

Event ID: 26D821

Facility ID: 00982

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	12/16/2013 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					0938-0391 SURVEY PLETED
		245552	B. WING			12/1	0/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	FY, STATE, ZIP CODE		
COLONI	AL MANOR OF BALA	TON		HIGHWAY 14 EAST P BALATON, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	Continued From particle of the second staff available records, the document the minine emergency generate conducted in the propractice was not in requirements at NF section 9.1.3. In a deficient practice corresidents, staff and FINDINGS INCLUE On 12/10/2013 at 1 facility's monthly test generator (genset), was not exercised as EPS nameplate ratit previous year. Furtise provided verifyin exercised using supplicad-banked, within deficient practice was not exercised as the provided verifyin exercised using supplicad-banked, within deficient practice was not exercised as the provided verifyin exercised using supplicad-banked, within deficient practice was not exercised as the provided verifyin exercised using supplicad-banked, within deficient practice was not exercised to the provided verifyin exercised using supplicad-banked, within deficient practice was not exercised to the provided verifyin exercised using supplicad-banked, within deficient practice was not exercised to the provided verifyin exercised using supplicad-banked, within deficient practice was not exercised to the pr	ge 5 s not met as evidenced by: interview and review of he facility was unable to num 30% loading of the or, during monthly load tests evious year. This deficient conformance with the PA 101 (2000) Chapter 9, fire or other emergency, this build adversely affect 33 of 33 visitors.	K 14	4 K 144 4.		will per d bank t tion of the erator. aff will y 30% lo cumentat f generat date of the test w 2013. The tor exer ests will per 31, 2 Ziegler , Shakop the annu The an Roge upervised tor Char sponsibl	form est, he bad tion ttor. ras cise 2013. ece, ual er d by cles

Facility ID: 00982

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