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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DXRH
Facility ID: 00302

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **6/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 07/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245572

July 9, 2014

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

Dear Ms. Goette:

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

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

Effective June 27, 2014, the above facility is certified for:

37 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

July 9, 2014

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

RE: Project Number S5572023

Dear Ms. Goette:

On May 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 25, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

In its notice dated May 14, 2014, this Department informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by June 4, 2014. Before a revisit was conducted, however, a survey team representing the Centers for Medicare &Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on May 16, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited at F431.

On May 27, 2014, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed.

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

In addition, as CMS notified you in its letter of May, 27, 2014, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), if your facility failed to achieve substantial compliance by July 25, 2014, your facility would be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014.

On June 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction; on June 3, 2014 the Minnesota Department of Public Safety completed a PCR; and on June 27, 2014, CMS completed an FMS PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed by the Minnesota Department of Health on April 25, 2014, and an FMS

survey completed May 16, 2014, respectively.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 25, 2014, effective June 27, 2014, therefore, remedies outlined in our letter to you dated May 14, 2014, will not be imposed.

Furthermore, as a result of the FMS PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of May 27, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

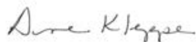
- Mandatory Denial of Payment for New Medicare and Medicaid, effective July 25, 2014, be rescinded (42 CFR 488.417 (b))

In the CMS letter of May 27, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), your facility would be prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on June 27, 2014, denial of payment for new admissions did not go into effect, therefore, the NATCEP prohibition is rescinded.

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 Forms, (CMS-2567B) from these visits.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	6/27/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**06/27/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**06/27/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**06/27/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**06/27/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**06/27/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**06/27/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**06/27/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	07/08/2014	32978	06/27/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/25/2014

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245572	01 - MAIN BUILDING 01	6/3/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	04/23/2014	ID Prefix Reg. # NFPA 101 LSC K0020	04/24/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/AK	07/08/2014	22373	6/03/2014
Reviewed By CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/23/2014			

FMS

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	6/27/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 06/02/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/02/2014	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/02/2014
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 06/02/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 06/02/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	07/08/2014	32978	06/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/16/2014			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245572

May 27, 2014
By Certified Mail and Facsimile

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

Dear Ms. Goette:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: April 25, 2014

STATE SURVEY RESULTS

On April 23, 2014, a Life Safety Code survey and on April 25, 2014, a health survey were completed at Colonial Manor Nursing Home by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level D, cited as follows:

- K18 -- S/S: D -- NFPA 101 -- Life Safety Code Standard
- K20 -- S/S: D -- NFPA 101 -- Life Safety Code Standard
- F241 -- S/S: D -- 483.15(a) -- Dignity and Respect of Individuality
- F246 -- S/S: D -- 483.15(e)(1) -- Reasonable Accommodation of Needs/Preferences
- F253 -- S/S: D -- 483.15(h)(2) -- Housekeeping & Maintenance Services
- F279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
- F280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise CP
- F315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent UTI, Restore Bladder
- F323 -- S/S: D -- 483.25(h) -- Free of Accident Hazards/Supervision/Devices

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY

In its notice dated May 14, 2014, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by June 4, 2014. Before a revisit was conducted, however, a survey team representing this office of the Centers for Medicare &

Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on May 16, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited at F431. The findings from the FMS are enclosed with this letter on form CMS-2567. Also enclosed is a list of the "resident identifiers" used in writing the Statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS-2567.

PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of

all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective July 25, 2014 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on July 25, 2014. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective July 25, 2014.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION
If your facility has not attained substantial compliance by October 25, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the

Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 25, 2014, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Colonial Manor Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A <u>written</u> request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132

Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring Survey, please contact Pamela Williams, RN, Team Leader, at (312) 886-2560. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)
Resident Identifier Key

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DXRH
Facility ID: 00302

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245572**
2.STATE VENDOR OR MEDICAID NO.
(L2) **075487000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY **04/25/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA**
02 SNF/NF/Dual **06 PRTF** **10 NF** **14 CORF**
03 SNF/NF/Distinct **07 X-Ray** **11 ICF/IID** **15 ASC**
04 SNF **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **37** (L18)
13.Total Certified Beds 37 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC
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
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Karen Beskar, HFE NE II 05/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DXRH
Facility ID: 00302

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA** **02 SNF/NF/Dual** **06 PRTF** **10 NF** **14 CORF** **03 SNF/NF/Distinct** **07 X-Ray** **11 ICF/IID** **15 ASC** **04 SNF** **08 OPT/SP** **12 RHC** **16 HOSPICE**

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 07/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00322** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/06/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245572

July 9, 2014

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

Dear Ms. Goette:

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

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

Effective June 27, 2014, the above facility is certified for:

37 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

July 9, 2014

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

RE: Project Number S5572023

Dear Ms. Goette:

On May 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 25, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

In its notice dated May 14, 2014, this Department informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by June 4, 2014. Before a revisit was conducted, however, a survey team representing the Centers for Medicare &Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on May 16, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited at F431.

On May 27, 2014, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed.

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

In addition, as CMS notified you in its letter of May, 27, 2014, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), if your facility failed to achieve substantial compliance by July 25, 2014, your facility would be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014.

On June 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction; on June 3, 2014 the Minnesota Department of Public Safety completed a PCR; and on June 27, 2014, CMS completed an FMS PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed by the Minnesota Department of Health on April 25, 2014, and an FMS

survey completed May 16, 2014, respectively.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 25, 2014, effective June 27, 2014, therefore, remedies outlined in our letter to you dated May 14, 2014, will not be imposed.

Furthermore, as a result of the FMS PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of May 27, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

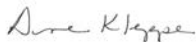
- Mandatory Denial of Payment for New Medicare and Medicaid, effective July 25, 2014, be rescinded (42 CFR 488.417 (b))

In the CMS letter of May 27, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), your facility would be prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on June 27, 2014, denial of payment for new admissions did not go into effect, therefore, the NATCEP prohibition is rescinded.

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 Forms, (CMS-2567B) from these visits.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	6/27/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	06/27/2014	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	06/27/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	06/27/2014
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	06/27/2014	ID Prefix F0315 Reg. # 483.25(d) LSC	06/27/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	06/27/2014
ID Prefix F0356 Reg. # 483.30(e) LSC	06/27/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	07/08/2014	32978	06/27/2014
CMS RO				

Followup to Survey Completed on: 4/25/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245572	01 - MAIN BUILDING 01	6/3/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	04/23/2014	ID Prefix Reg. # NFPA 101 LSC K0020	04/24/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	07/08/2014	22373	6/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/23/2014			

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

FMS

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	6/27/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	06/02/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	06/02/2014	ID Prefix F0309 Reg. # 483.25 LSC	06/02/2014
ID Prefix F0329 Reg. # 483.25(l) LSC	06/02/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	06/02/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By SR/AK	Date: 07/08/2014	Signature of Surveyor: 32978	Date: 06/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/16/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245572

May 27, 2014
By Certified Mail and Facsimile

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

Dear Ms. Goette:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: April 25, 2014

STATE SURVEY RESULTS

On April 23, 2014, a Life Safety Code survey and on April 25, 2014, a health survey were completed at Colonial Manor Nursing Home by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level D, cited as follows:

- K18 -- S/S: D -- NFPA 101 -- Life Safety Code Standard
- K20 -- S/S: D -- NFPA 101 -- Life Safety Code Standard
- F241 -- S/S: D -- 483.15(a) -- Dignity and Respect of Individuality
- F246 -- S/S: D -- 483.15(e)(1) -- Reasonable Accommodation of Needs/Preferences
- F253 -- S/S: D -- 483.15(h)(2) -- Housekeeping & Maintenance Services
- F279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
- F280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise CP
- F315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent UTI, Restore Bladder
- F323 -- S/S: D -- 483.25(h) -- Free of Accident Hazards/Supervision/Devices

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY

In its notice dated May 14, 2014, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by June 4, 2014. Before a revisit was conducted, however, a survey team representing this office of the Centers for Medicare &

Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on May 16, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited at F431. The findings from the FMS are enclosed with this letter on form CMS-2567. Also enclosed is a list of the "resident identifiers" used in writing the Statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS-2567.

PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of

all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective July 25, 2014 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on July 25, 2014. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective July 25, 2014.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION
If your facility has not attained substantial compliance by October 25, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the

Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 25, 2014, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Colonial Manor Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A <u>written</u> request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132

Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring Survey, please contact Pamela Williams, RN, Team Leader, at (312) 886-2560. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)
Resident Identifier Key

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5572

At the time of the standard survey completed 4/25/14, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

In addition, CMS surveyors conducted a Federal Monitoring Survey (FMS). Deficiencies were found and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) . CMS notified the facility of the results of the FMS.

The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5057

May 14, 2014

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

RE: Project Number S5572023

Dear Ms. Goette:

On April 25, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 June 4, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 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

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 July 25, 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 October 25, 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:

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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified

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 about this letter.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING ______ B. WING ______	04/25/2014

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

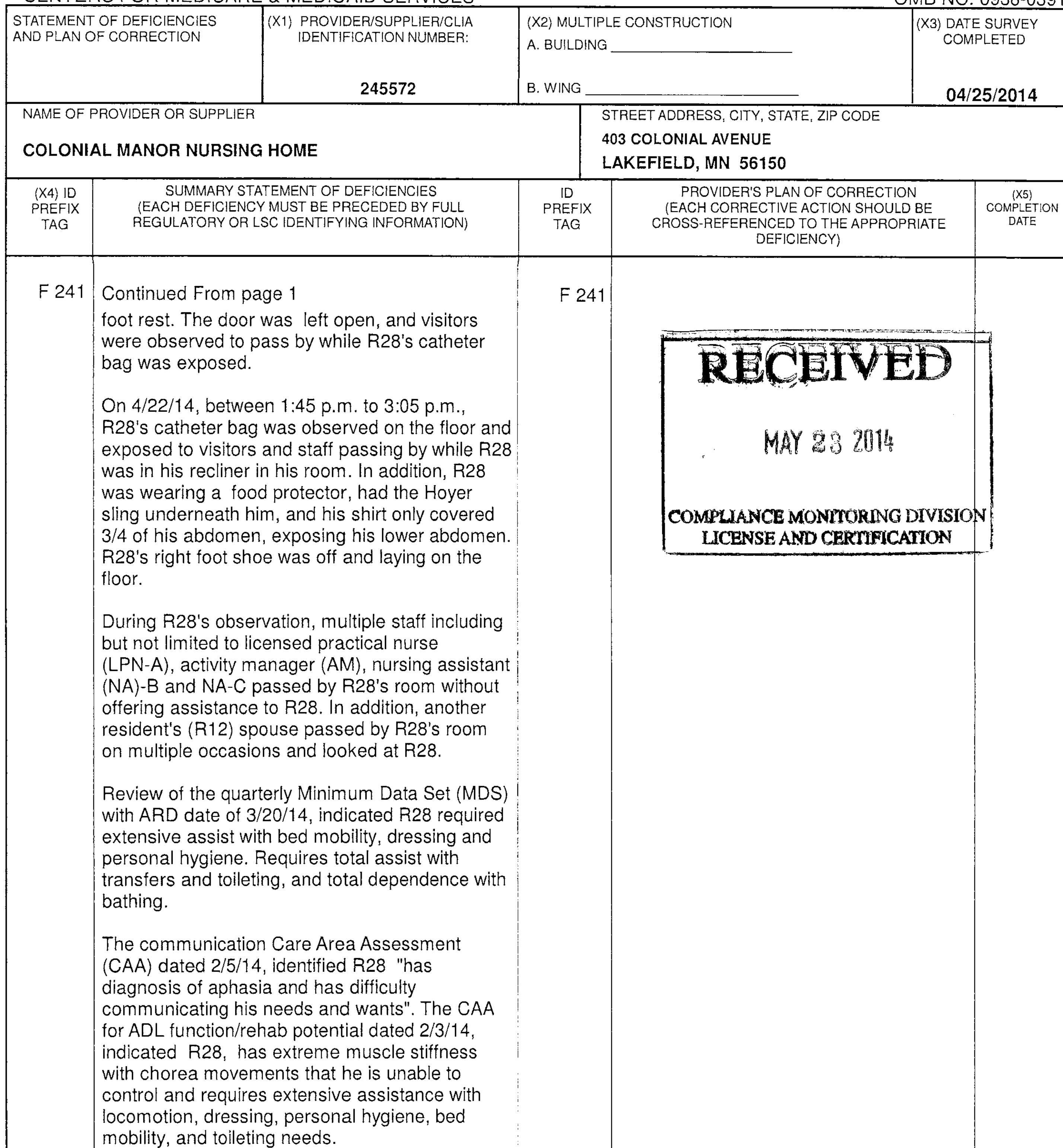
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F241 DIGNITY AND RESPECT OF INDIVIDUALITY Corrective Action: To assure that the facility promotes dignity and respect for all of its residents. For R28 this was corrected with the change of new foley bags called "Fig Leaf" bags which have a permanent cover attached to the foley bag. Education was provided to all staff on April 29 & 30, 2014 regarding the change in catheter bags and re-educating staff on the importance of not having foley bags touching the floor.	5/30/14
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 cover a urinary catheter bag, in a manner that was dignified, for 1 of 1 resident (R28) in the sample with an indwelling urinary catheter. Findings include: R28 was observed in his room 4/22/14, between 9:37 a.m. to 10:39 a.m. R28's urinary catheter bag was not covered or placed in the drainage bag holder and was visible to anyone who looked in R28's room. The catheter drainage bag was observed to contain approximately 400 cc of urine and was hanging on the metal bar of the recliner	F 241 5/17/14 SEH	Future Prevention: Recurrence with future residents will be prevented with the implementation of a new policy and procedure regarding the use of "Fig Leaf" bags with a permanent cover resulting in increased dignity for all residents that have a foley catheter. Monitoring for Compliance: Only Fig Leaf bags will be used and a licensed nurse will do checks daily on alternating shifts for proper placement of foley drain bags and tubing. Education also being provide to all staff regarding the facility's need to promote care for each resident in a manner that maintains and enhances each resident's dignity. Future Prevention: Staff will receive education annually and new employees will also receive information at orientation regarding dignity. Corrective Action completed by 5/30/2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrice Hoitte	Administrator	5/22/14

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
	245572	A. BUILDING ____ B. WING ____	04/25/2014

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



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 foot rest. The door was left open, and visitors were observed to pass by while R28's catheter bag was exposed. On 4/22/14, between 1:45 p.m. to 3:05 p.m., R28's catheter bag was observed on the floor and exposed to visitors and staff passing by while R28 was in his recliner in his room. In addition, R28 was wearing a food protector, had the Hoyer sling underneath him, and his shirt only covered 3/4 of his abdomen, exposing his lower abdomen. R28's right foot shoe was off and laying on the floor. During R28's observation, multiple staff including but not limited to licensed practical nurse (LPN-A), activity manager (AM), nursing assistant (NA)-B and NA-C passed by R28's room without offering assistance to R28. In addition, another resident's (R12) spouse passed by R28's room on multiple occasions and looked at R28. Review of the quarterly Minimum Data Set (MDS) with ARD date of 3/20/14, indicated R28 required extensive assist with bed mobility, dressing and personal hygiene. Requires total assist with transfers and toileting, and total dependence with bathing. The communication Care Area Assessment (CAA) dated 2/5/14, identified R28 "has diagnosis of aphasia and has difficulty communicating his needs and wants". The CAA for ADL function/rehab potential dated 2/3/14, indicated R28, has extreme muscle stiffness with chorea movements that he is unable to control and requires extensive assistance with locomotion, dressing, personal hygiene, bed mobility, and toileting needs.	F 241	RECEIVED MAY 23 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING ______ B. WING ______	04/25/2014

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F 241	Continued From page 2	F 241		

Care plan, dated 2/5/14, "potential for urinary tract infection r/t h/o recurrent UTI'S, and indwelling Foley catheter. Also addressed goal (Resident will remain free of signs and symptoms of urinary tract infection through the review date.) and intervention (catheter care with AM and PM cares ... .). " Also indicated R28 required staff assistance with activities of daily living (ADLs). Goal "Will be dry and odor free through the review date." The care plan directed staff to ensure clothing/appearance is appropriate.

During an attempt to interview, R28 on 4/23/14, at 9:23 a.m., R28 was aphasic and was not interviewable.

During an interview with registered nurse (RN-B) on 4/23/14, at 10:55 a.m. stated, the catheter bag should be covered in drainage bag holder and further stated, "Yes, we have covers for that."

During an interview with RN-A on 4/23/14, at 12:51 p.m. RN-A stated, The Foley catheter draininage bag should be covered and the Foley catheter being on the floor, should not be on the floor.

During an interview with director of nursing (DON) on 4/24/14, at 11:32 a.m., DON stated, "My expectations are, when residenst are not in bed, I expect the Foley drainage bag to be in the bag holder. DON indicated, "We need to do re-education" and "it was a concern for me when I heard it."

Policy and procedure with reviewed and revised date February 18, 2013, reads, "All Foley catheter bags must be placed in a drainage bag holder

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 3 when the resident is in a wheelchair, recliner, geri-chair, or up ambulating to restore the dignity of the resident."	F 241	F253 HOUSEKEEPING & MAINTENANCE SERVICES Corrective Action: To assure that the facility provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior the facility had a floor cleaning vendor inspect the flooring on 4/28/2014, facility ordered new equipment for floor cleaning on 4/30/2014, the floor vendor will complete training on 5/27/2014 of the new equipment with the cleaning of R43 room. All resident rooms will be put on a floor cleaning schedule with the following R42, R18, R31 and R39 to be completed first. R18 signed an agreement to have her room thoroughly cleaned with the removal of all items from her room once every 3 months. The west shower room received a new covered garbage can on 4/25/2014, the shower area will be retiled by contractors by 5/30/2014. R42 received a new bedside table on 4/29/2014. A new policy and procedure was initiated regarding deep cleaning and the house-keeping department received education on 5/21/2014. To prevent future recurrences the house-keeping department will maintain daily documentation on all rooms cleaned and bedside table observations. Monitoring will be done by the House-keeping Supervisor through random audits and findings will be discussed at monthly internal QAMeetings. Corrective action for cleaning of the dining room tables will be that all dining room tables will be cleaned after every meal and afternoon coffee time by dietary staff, this will be documented after every cleaning, staff education to be provided on 5/28/2014. Monitoring will be random audits by the Dietary Manager and findings to be reviewed at monthly internal QA meetings. Corrective Action Completed by: 5/30/2014	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were kept clean and in good repair for 5 of 34 resident rooms (R43, R18, R31, R42, R39) observed during survey. Findings include: Observations during the initial tour on 4/21/14 at 6:30 p.m., and environmental tour on 4/24/14 at 4:20 p.m., with the director of nursing, revealed the following: R43's bathroom floor was observed to be soiled, The bathroom floor which lined up to the bedroom floor, was noted to be soiled with yellowish build up. The director of nursing indicated it was wax build up. R18's bedroom contained large amounts of personal belongings including a lounge chair, tables, stacks of magazines etc. There was minimal walk space in the room. R18 ate all meals in the room. R18 indicated not knowing when staff had cleaned the whole floor, changed the top bedspread on bed etc. The floor was soiled and spotted, and the window ledge was dusty. The bathroom had soiled towels on the floor by the toilet and on the arm of the toilet	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING ______ B. WING ______	04/25/2014

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

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F 253	Continued From page 4 riser. The director of nursing agreed with the findings and indicated the need to come up with a plan, agreeable to resident, how often and when to clean room. The west side shower room contained a medium size trash can that did not have a lid. On initial tour, the trash container contained soiled briefs. The room had a pungent foul odor. The shower area had white tiles with grout that had black markings and discoloring. During environment tour on 4/24/14 at 4:20 p.m., the director of nursing agreed the shower looked old and in need of repair/cleaning. The DON verified the trash bin was near the shower and did not have a lid. R31's bedroom floor was soiled with wax buildup near the bathroom entrance. R42, during stage I interview, 4/22/14, at 10:56 a.m., stated, the bathroom floor does not get cleaned routinely. The floor was observed to have dark brown colored stains. On 4/24/14, at 2:30 p.m. environmental tour was conducted with the Environmental services and on 4/24/14 at 2:50 p.m., the tour continued with the DON. The following was identified: On 4/24/14, at 2:50 p.m.the dark brown colored stained flooring remained in R42's bathroom. The stains were observed to be rubbery or glue like. In addition, R42's bed side table was noted to be dusty and sticky. On 4/24/14, at 2:54 p.m., the director of nursing (DON) indicated the stains on the floor were glue or rubbery substance and stated the surface would be hard to clean. In addition, DON stated, "That is the way the table is and it needs to be	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 5 replaced, we have ordered new tables and we will replace it." As for the bathroom floor, DON indicated it felt like glue or a rubbery substance and would check to see what could be done about it. During an interview with R39 on 4/22/14, at 1:55 p.m., R39 stated tht the dining room tables are normally dirty when they come into the dining room. The facility policy and procedure titled Housekeeping - Cleaning, dated October 2013, reads, "Policy: It is the policy of this facility that housekeeping keep the environment clean and safe." Further indicated, "Procedure: 1. Resident rooms are deep cleaned on an every other day basis. 2. Resident bathrooms and garbages are cleaned on a daily basis."	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	F279 DEVELOP COMPREHENSIVE CARE PLANS Corrective Action: To assure that the facility properly develops comprehensive care plans – R34 care plan was corrected on 4/23/2014 to include interventions identified for urinary catheter care and other resident care plans were reviewed and verified by the MDS Coordinator that interventions for catheter care are on the resident care plans. To prevent Recurrence of this deficiency, MDS Coordinator will assure that all completed assessments are reflected by completing an assessment and tracking log form that will be randomly audited by the Director of Nursing. Corrective Action Completed by 5/01/2014.	

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F 279	Continued From page 6 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop interventions on the care plan based on comprehensive assessments for 1 of 1 resident (R34) reviewed for catheter use. Findings include: R34 had diagnosis of urethral stricture, dated 10/3/13, which resulted in urine retention, requiring the use of a urinary catheter, per record review. Review of the significant change Minimum Data Set (MDS,) dated 2/28/14, indicated R34 had moderate cognition impairment. It also indicated the use of an indwelling Foley catheter and extensive assist with toileting. R34's Care Area Assessment (CAA) dated 3/6/14, indicated the use of an indwelling Foley catheter related to urinary retention and urethral stricture. Catheter and catheter bag was changed per physician orders/protocol. The urinary bag was kept below the level of the bladder and emptied every shift with routine catheter cares. Proceed to care plan. R34's care plan dated 3/6/14 indicated occasional urinary incontinence with a history of urine retention. There were no interventions identified for urinary catheter care. During an interview on 4/23/14, at 2:20 p.m. with both director of nursing (DON) and MDS coordinator verified R34's care plan did not provide interventions for catheter care. The facility policy titled, Care Planning IDT, dated	F 279		

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F 279	Continued From page 7 2/1/2013 indicated, Nursing Care Plan was reviewed and updated as needed, but not less than monthly by a nurse.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reassess the effectiveness and revise interventions for 3 of 4 residents (R26,R32, R15) that were reviewed for accidents. Findings include: R26's diagnoses included weakness, dementia, hearing loss, severe vision impairment and a history of falls. The quarterly minimum data set	F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Corrective action: To assure that care plans are reviewed and revised as needed – correction for R26 care plan reviewed and current as of 4/25/2014. R32 care plan reviewed and revised as of 5/20/2014. Incident reporting forms have been revised on 4/26/2014 and 5/16/2014 to include the fall investigation and fall risk analysis to assure that root cause analysis is completed with all falls and will be discussed at IDT Standup meetings. Policy and procedure reviewed and revised. To prevent future recurrence the fall risk analysis will be completed initially on admit, annually, quarterly, with hospital returns, significant changes and post fall. Education to licensed nurses was completed on 4/29/2014 and 5/21/2014 with further revisions. Monitoring – Post Fall Risk Analysis Reports will be reviewed at monthly QA meetings. Corrective Action completed by 5/21/2014.	[illegible]

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F 280	Continued From page 8 (MDS) dated 4/14/14 indicated R26 had a moderate cognitive impairment. R26 also required physical assist of one for toileting, transferring and mobility. There were no behaviors towards others or rejection of cares noted. All completed fall risk assessments indicated R26 was at high risk for falls. Incident reports were as follows: 11/15/13 at 2:30 a.m. indicated R26 fell trying to use the restroom. Staff was instructed to continue current interventions. On 4/7/14 at 11:00 a.m. indicated R26 fell in the bathroom. Staff was instructed to continue current intervention and strongly encouraged resident to use call light and wait for assistance. On 4/20/14 at 11:40 a.m., indicated R26 fell on the floor when attempting to self-transfer. Staff were instructed to encourage and remind resident to use call light. R26's care plan indicated the potential for falls, however, there were no new interventions put into place to prevent future incidents. Director of nursing (DON) and MDS coordinator were interviewed on 4/23/14 at 2:00 p.m. and verified R26 had no falls since November 2013 and then had two falls in April 2014. They further indicated that R26 fell when attempting to use the bathroom independently and verified that no other interventions have been attempted to prevent falls. R32's diagnoses include dementia and a history of falls. The quarterly MDS dated 4/4/14 indicated R32 had severe cognitive impairment. R32 also required extensive physical assist of one to two staff for transferring, toileting, mobility and other care areas. There were no behaviors towards others or rejection of cares noted. All completed	F 280		

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F 280	Continued From page 9	F 280		

fall risk assessments indicated R32 was at high risk for falls.

Fall reports for the past six months were as follows:

On 11/1/13, at 3:15 p.m. R32 had attempted to self-transfer. Staff was instructed to continue current interventions.

On 12/20/13, at 4:25 p.m. R32 was found on the floor by recliner chair. Staff was instructed to continue current interventions.

On 2/8/14, at 3:00 p.m. R32 crawled out of the recliner chair and was on the floor. Staff was instructed to continue current interventions.

On 3/24/14, at 2:25 p.m. R32 was found sitting on the floor by recliner chair. Staff was instructed to continue current interventions.

On 4/16/14 at 2:40 p.m. R32 was found on the floor by recliner chair. Staff was instructed to continue current interventions.

R32's care plan indicated the potential for falls, but there were no new interventions put into place to prevent future incidents.

The MDS coordinator was interviewed on 4/23/14, at 10:45 a.m., and indicated R32 has had numerous falls. Stated R32 has a pressure alarm and a TABS alarm. The alarms notify staff of R32's movement, but was unsure if they actually prevented the falls.

DON and MDS coordinator were interviewed on 4/23/14, at 2:00 p.m. and verified R32 continued

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F 280	Continued From page 10 to fall with current interventions in place and that no other interventions had been attempted to prevent future incidents. The DON further stated that a meeting is held the day after a fall to discuss the details of the fall, what the cause of the fall could be, and possible interventions they could put into place to prevent future incidents. The facility policy titled, "Incident Reporting-Resident", revised July 2013, indicated all incidents are reported in a timely manner to ensure that resident care plans adequately reflect resident care needs. It also instructs the DON/designee to ensure that the resident care plan is revised/updated as necessary based on the incident report. R15 had three falls since admission on 2/11/14, and the care plan had not been reviewed and revised as to the root cause analysis of the falls. R15 was admitted 2/11/14 for generalized weakness, heart failure, and difficulty walking. Review of falls since admission were: 3/13/14 at 0200 R15 was found next to the bed sitting upright. She said she was going to the bathroom (BR) and when she stood up her feet slipped and she fell onto her butt. R15 had no injuries. R15 was educated on need to use call light when needing to go to the BR. care plan (CP) updated to add alarm to bed. 4/7/14 0205 found on floor next to bed. Trying to get up and slipped. No indication of what resident was trying to do. Resident had no injuries. CP was updated to add alarming fall mat next to bed. 4/9/14 at 0605 fell in room while ambulating self	F 280		

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F 280	Continued From page 11 to BR. Obtained a skin tear to the elbow. She said she needed to use the BR. The alarming floor mat was under the bed and R15 had turned off the pressure alarm and did not use the call light. The admission minimum data set (MDS) dated 2/18/14 indicated a brief interview for mental status (BIMS) score of 13, which indicated very mild cognition deficits. R15 did not have a prior fall history. The care area assessments (CAAS) indicated a fall risk due to balance deficits due to weakness. A fall assessment dated 2/18/14, R15 scored a 17 (12 or more indicated high risk). The CP, developed 2/24/14 and updated on 4/7/14 and 4/9/14 indicated R15 was a fall risk due to weakness and impaired mobility with recent falls. Interventions included a pressure sensor alarm when in bed (placed on 4/1/14), alarming fall mat next to bed (placed on 4/7/14), and a magnet shut off pressure alarm at all times in bed and in wheel chair (placed 4/9/14). The toileting care plan dated 4/9/14 indicated staff to assist as needed. Interview with registered nurse (RN)-A on 4/24/14 at 10:30 a.m., identified that all falls seemed to be related to wanting to get up to go to BR and indicated staff should probably look at a toileting program at night and add it to the care plan.	F 280		
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	F 315		

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F 315	Continued From page 12 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 record review the facility failed to provide appropriate urinary catheter cares to 1 of 1 resident (R34) who was reviewed for catheter use. Findings include: Review of R34's record, identifie R34 had diagnoses of stage three chronic kidney disease and urethral stricture dated 10/3/13, which resulted in urine retention requiring the use of a urinary catheter. Significant change Minimum Data Set (MDS), dated 2/28/14, indicated R34 had moderate cognition impairment. It also indicated the use of an indwelling foley catheter and extensive assist with toileting. R34's Care Area Assessment (CAA), dated 3/6/14, indicated the use of an indwelling foley catheter related to urinary retention and urethral stricture. Catheter and catheter bag is changed per orders/protocol. Bag is kept below the level of the bladder and emptied every shift with routine catheter cares. Proceed to care plan. Care plan, dated 3/6/2014, for toileting and continence indicated R34 had occasional urinary incontinence with a history of urinary retention. There was no information regarding the use of a urinary catheter in R34's plan of care On 4/22/14, at 9:00 a.m., R34 was observed to	F 315	F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER Corrective Action: To assure that the facility care plans Foley catheters and the goals including appropriate interventions – R34 correction completed on 4/24/2014 - care plan updated to include goal of keeping catheter bag below the bladder level and risk factors if policy not followed. Staff education provided on catheter care 4/29/2014. Care plans of residents with catheters were reviewed to ensure they address keeping catheter bag below the bladder and risk factors were addressed. The MDS Coordinator will assure that all completed assessments are reflected on the care plan by completing an assessment completion and care plan tracking log form. The Director of Nursing will do random audits to check that care plans are completed appropriately and findings reviewed at monthly internal QA meeting. Corrective Action completed by 5/1/2014.	5/1/14

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F 315	Continued From page 13 have a urinary catheter tube extending from the bottom of the left pant leg up to the knee and under the wheelchair seatbelt. The catheter drainage bag hung at waist level on the left side of the wheelchair. Numerous observations were made throughout the survey of similar positioning. DON was interviewed on 4/23/14, at 2:20 p.m., and stated that many attempts had been made to position the urinary drainage bag to a lower level, but R34 refused. DON also stated R34 had been educated about the potential risk of infection due to the positioning of the urinary drainage bag, but continued to want it hung on the left side of the wheelchair at waist level. DON confirmed there was no information in R34's plan of care addressing the use of a urinary catheter. R34 was interviewed on 4/24/14, at 8:30 a.m. and expressed concern that the catheter drainage bag and tubing would get caught in the wheelchair wheels. During the interview, DON moved the catheter drainage bag to R34's feet, and encouraged R34 to keep urinary drainage bag at the lower level. There was no documentation found in the chart that R34 had been previously educated on the risk of infection due to urinary drainage bag positioning. The facility's policy titled, "Catheter Care", revised 2/13/2013, indicated the collection bag should not be raised above the level of the bladder.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to ensure a thorough investigation of the root cause analysis and adequate interventions were implemented to minimize the risk for falls for 3 of 4 residents (R26, R32, R15) reviewed, who were identified at risk for falls. Findings include: Review of R26's record, identified diagnoses to include weakness, dementia, hearing loss, severe vision impairment and a history of falls. The quarterly minimum data set (MDS) dated 4/14/14 indicated R26 had a moderate cognitive impairment. R26 also required physical assist of one for toileting, transferring and mobility. There were no behaviors towards others or rejection of cares noted. R26's care plan indicated the potential for falls, however, there were no new interventions put into place to prevent future incidents. All completed fall risk assessments indicated R26 was at high risk for falls. Incident reports were as follows: 11/15/13 at 2:30 a.m. indicated R26 fell trying to use the restroom. Staff was instructed to continue current interventions. On 4/7/14 at 11:00 a.m. indicated R26 fell in the bathroom. Staff was instructed to continue current intervention and strongly encouraged	F 323	F323 FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES Corrective Action: To assure that care plans are reviewed and revisions made as needed. R26 corrections include review of care plan and is current as of 4/25/2014. R32 corrections include review of care plan with the following revision on 5/9/2014, removal of recliner with family consent and change of position to include laying in bed for rest periods. R15 corrections include review of care plan and revision as of 5/20/2014 which includes toilet prompting every 2 hours during night time hours. Incident reporting forms have been revised on 4/29/2014 and 5/16/2014 to include the fall investigation and fall risk analysis to assure that root cause analysis is completed with all falls and will be discussed at IDT Standup meetings. Policy and procedures reviewed and revised. To prevent future recurrence the fall risk analysis will be completed initially on admit, annually, quarterly, with hospital returns, significant changes and post fall. Education to licensed nurses completed on 4/29/2014 and 5/21/2014 with further revisions. Monitoring – post fall risk analysis reports will be discussed at IDT Standup meetings and monthly internal QA meetings. Corrective Action completed by 5/21/2014.	5/21/14

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F 323	Continued From page 15 resident to use call light and wait for assistance. On 4/20/14 at 11:40 a.m. indicated R26 fell on the floor when attempting to self-transfer. Staff were instructed to encourage and remind resident to use call light. The director of nursing (DON) and minimum data set (MDS) coordinator were interviewed on 4/23/14 at 2:00 p.m. and verified R26 had one fall in November 2013 and then two falls in April 2014, all of which occurred when R26 attempted to use the bathroom independently. They further verified that no other interventions had been attempted to prevent future falls. R32's record, identified diagnoses to include dementia and a history of falls. The quarterly MDS dated 4/4/14 indicated R32 had severe cognitive impairment. R32 also required extensive physical assist of one to two staff for transferring, toileting, mobility and other care areas. There were no behaviors towards others or rejection of cares noted. R32's care plan indicated the potential for falls, but there were no new interventions put into place to prevent future incidents. All completed fall risk assessments indicated R32 was at high risk for falls. Fall reports for the past six months were as follows: On 11/1/13, at 3:15 p.m. R32 had attempted to self-transfer. Staff was instructed to continue current interventions. On 12/20/13, at 4:25 p.m. R32 was found on the floor by recliner chair. Staff was instructed to continue current interventions. On 2/8/14, at 3:00 p.m. R32 crawled out of the recliner chair and was on the floor. Staff was	F 323		

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F 323	Continued From page 16 instructed to continue current interventions. On 3/24/14, at 2:25 p.m. R32 was found sitting on the floor by recliner chair. Staff was instructed to continue current interventions. On 4/16/14 at 2:40 p.m. R32 was found on the floor by recliner chair. Staff was instructed to continue current interventions. The minimum data set (MDS) coordinator was interviewed on 4/23/14, at 10:45 a.m. It was verified that R32 has had numerous falls even though there was a pressure alarm and a TABS alarm being used. MDS coordinator further indicated the alarms will sound with any type of movement, but she was unsure if alarms would prevent a fall from occurring. An interview was completed with the director of nursing (DON) and MDS coordinator on 4/23/14, at 2:00 p.m. and both verified R32 continued to fall with current interventions in place and that no other interventions had been attempted to prevent future incidents. The DON further stated that a meeting is held the day after a fall to discuss the details of the fall, the cause of the fall, and possible interventions they could put into place to prevent future incidents. The facility policy titled "Incident Reporting-Resident" revised July 2013 indicated all incidents (which included falls witnessed or unwitnessed) are reported in a timely manner to ensure that resident care plans adequately reflect resident care needs. It also instructs the DON/designee ensures that the resident care plan is revised/updated as necessary based on the incident report. R15 had three falls since admission on 2/11/14,	F 323		

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F 323	Continued From page 17	F 323		

and a causal factor for the falls had not been determined and interventions put in place to minimize the risk of falls. R15 was admitted 2/11/14 for generalized weakness, heart failure, and difficulty walking.

Falls since admission were:
3/13/14 at 0200 R15 was found next to the bed sitting upright. She said she was going to the bathroom (BR) and when she stood up her feet slipped and she fell onto her butt. R15 had no injuries. R15 was educated on need to use call light when needing to go to the BR. CP updated to add alarm to bed.
4/7/14 0205 found on floor next to bed. Trying to get up and slipped. No indication of what resident was trying to do. Resident had no injuries. CP was updated to add alarming fall mat next to bed.
4/9/14 at 0605 fell in room while ambulating self to BR. Obtained a skin tear to the elbow. She said she needed to use the BR. The alarming floor mat was under the bed and R15 had turned off the pressure alarm and did not use the call light.

The admission minimum data set (MDS) dated 2/18/14 indicated a brief interview for mental status (BIMS) score of 13, which indicated very mild cognition deficits. R15 did not have a prior fall history. The care area assessments (CAAS) indicated a fall risk due to balance deficits due to weakness. A fall assessment dated 2/18/14, R15 scored a 17 (12 or more indicated high risk). The care plan (CP) developed 2/24/14 and updated on 4/7/14 and 4/9/14 indicated R15 was a fall risk due to weakness and impaired mobility with recent falls. Interventions included a pressure sensor alarm when in bed (placed on 4/1/14), alarming fall mat next to bed (placed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING ______ B. WING ______	04/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 4/7/14), and a magnet shut off pressure alarm at all times in bed and in wheel chair (placed 4/9/14). The toileting care plan dated 4/9/14 indicated staff to assist as needed. Interview with registered nurse (RN)-A on 4/24/14 at 10:30 a.m. indicated the falls seem to be related to wanting to get up to go to BR and that staff had not done a thorough analysis of the falls to put interventions into place to minimize the risk of falls.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	F356 POSTED NURSE STAFFING INFORMATION Corrective Action: To assure that the facility has the posting of staff and staff hours posted correctly and in a visible area that is accessible to all residents and visitors – Facility name was added to posting on 4/24/2014 and was placed right next to the business office door on 4/25/2014 which is accessible/visible to all residents and visitors. To prevent future recurrences licensed nurses were educated on the appropriate placement of information. Corrective Action Completed by 4/29/2014.	4/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING ______ B. WING ______	04/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 19	F 356		

standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure posted nursing hours accurately identified the facility and were displayed in a prominent place readily accessible to residents and visitors. This had the potential to affect all 34 residents and any facility visitors.

Findings include:

Posted nursing hours were not displayed in a readily accessible place for residents and visitors and the posting lacked the facility name.

Posted nursing hours were observed during an initial tour of the facility on 4/21/14 at 6:30 p.m. Although the posting included vital information such as census, specific personnel and total numbers of hours worked, the posting failed to identify the full facility's name. Also, the nursing hours were posted in the entrance area separated by a entrance door. Residents and/or visitors needed to open a door from inside the facility to get to the posting.

The postings for 4/20, 4/21, 4/22 and 4/23, were reviewed. Each of these postings lacked identification of the facility's name and were located on the wall in the entrance of the building. Residents and visitors did not have readily accessible availability to the posting.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING ______ B. WING ______	04/25/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 20 On 4/24/14 at 2:00 p.m. the director of nursing (DON) reported the nursing staff fills out the forms and posts it at start of the new day. The DON reported she was not aware the facility's name was required and would fix it promptly. When informed of the location not being readily accessible to residents and visitors, the DON indicated the location of the posting would be changed.	F 356		

F 5572023

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

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	245572	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	04/23/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 April 23, 2014. At the time of this survey, Colonial Manor Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok R 5-29-14 LAST DATE OF CORRECTION 4-24-14 RECEIVED MAY 27 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 6-4-14
EXIT: 4-23-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrice Goette
TITLE: Administrator
(X6) DATE: 5-22-14

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
	245572	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/23/2014

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Colonial Manor Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1979, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1999, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 34 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/23/2014

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

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain one or more corridor doors in the means of egress, 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 12 of 37 residents. FINDINGS INCLUDE: On 04/23/2014 at 12:55 PM, observation revealed	K 018	K018 The latch on the corridor door to the storage room on the NW Hall was removed and the missing hardware was installed appropriately. The Maintenance Director will check all corridor doors in the means of egress when doing his monthly walk through. Date of completion: 04/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/23/2014

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K 018	Continued From page 3 the corridor door to the Storage Room on the Northwest Corridor did not positively latch into its frame, as the latching hardware was missing. This finding was verified with the chief building engineer at the time of discovery.	K 018		
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the required fire resistance rating of a stairway, in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.1 and Chapter 8, Section 8.2. In the event of a fire in the basement, this deficient practice could adversely affect 20 of 37 residents, staff and visitors. FINDINGS INCLUDE: On 04/23/2014 at 1:05 PM, while surveying on the basement level, observation revealed the exit door to the southwest basement stairway did not positively latch into its frame, as the latching hardware was out of adjustment. This finding was verified with the chief building engineer at the time of discovery.	K 020	K020 The latch on the exit door to the SW basement stairway was adjusted to close appropriately. The Maintenance Director will check all doors for appropriate closing/latching when doing his monthly walk through of the facility. Date of completion: 04/24/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DXRH

Facility ID: 00302

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 07/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245572

July 9, 2014

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

Dear Ms. Goette:

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

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

Effective June 27, 2014, the above facility is certified for:

37 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

July 9, 2014

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

RE: Project Number S5572023

Dear Ms. Goette:

On May 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 25, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

In its notice dated May 14, 2014, this Department informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by June 4, 2014. Before a revisit was conducted, however, a survey team representing the Centers for Medicare &Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on May 16, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited at F431.

On May 27, 2014, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed.

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

In addition, as CMS notified you in its letter of May, 27, 2014, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), if your facility failed to achieve substantial compliance by July 25, 2014, your facility would be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014.

On June 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction; on June 3, 2014 the Minnesota Department of Public Safety completed a PCR; and on June 27, 2014, CMS completed an FMS PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed by the Minnesota Department of Health on April 25, 2014, and an FMS

survey completed May 16, 2014, respectively.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 25, 2014, effective June 27, 2014, therefore, remedies outlined in our letter to you dated May 14, 2014, will not be imposed.

Furthermore, as a result of the FMS PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of May 27, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

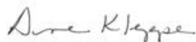
- Mandatory Denial of Payment for New Medicare and Medicaid, effective July 25, 2014, be rescinded (42 CFR 488.417 (b))

In the CMS letter of May 27, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), your facility would be prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on June 27, 2014, denial of payment for new admissions did not go into effect, therefore, the NATCEP prohibition is rescinded.

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 Forms, (CMS-2567B) from these visits.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	6/27/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	06/27/2014	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	06/27/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	06/27/2014
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	06/27/2014	ID Prefix F0315 Reg. # 483.25(d) LSC	06/27/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	06/27/2014
ID Prefix F0356 Reg. # 483.30(e) LSC	06/27/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	07/08/2014	32978	06/27/2014
CMS RO				

Followup to Survey Completed on: 4/25/2014

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245572	01 - MAIN BUILDING 01	6/3/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	04/23/2014	ID Prefix Reg. # NFPA 101 LSC K0020	04/24/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	07/08/2014	22373	6/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/23/2014

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

FMS

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245572	A. Building B. Wing	6/27/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 06/02/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/02/2014	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/02/2014
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 06/02/2014	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 06/02/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	07/08/2014	32978	06/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/16/2014			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245572

May 27, 2014
By Certified Mail and Facsimile

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

Dear Ms. Goette:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: April 25, 2014

STATE SURVEY RESULTS

On April 23, 2014, a Life Safety Code survey and on April 25, 2014, a health survey were completed at Colonial Manor Nursing Home by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level D, cited as follows:

- K18 -- S/S: D -- NFPA 101 -- Life Safety Code Standard
- K20 -- S/S: D -- NFPA 101 -- Life Safety Code Standard
- F241 -- S/S: D -- 483.15(a) -- Dignity and Respect of Individuality
- F246 -- S/S: D -- 483.15(e)(1) -- Reasonable Accommodation of Needs/Preferences
- F253 -- S/S: D -- 483.15(h)(2) -- Housekeeping & Maintenance Services
- F279 -- S/S: D -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
- F280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right to Participate Planning Care-Revise CP
- F315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent UTI, Restore Bladder
- F323 -- S/S: D -- 483.25(h) -- Free of Accident Hazards/Supervision/Devices

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY

In its notice dated May 14, 2014, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by June 4, 2014. Before a revisit was conducted, however, a survey team representing this office of the Centers for Medicare &

Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on May 16, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited at F431. The findings from the FMS are enclosed with this letter on form CMS-2567. Also enclosed is a list of the "resident identifiers" used in writing the Statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS-2567.

PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of

all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective July 25, 2014 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on July 25, 2014. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective July 25, 2014.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION
If your facility has not attained substantial compliance by October 25, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the

Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 25, 2014, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Colonial Manor Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2014. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 25, 2014

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A written request for a hearing must be filed no later than 60 days from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132

Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring Survey, please contact Pamela Williams, RN, Team Leader, at (312) 886-2560. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)
Resident Identifier Key

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health