



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 12, 2025

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

RE: CCN: 245572
Cycle Start Date: November 21, 2024

Dear Administrator:

On January 27, 2025, we notified you a remedy was imposed. On February 6, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 28, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 21, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 27, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 21, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 28, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 12, 2025

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

Re: Reinspection Results
Event ID: E7X012

Dear Administrator:

On January 16, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 21, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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January 27, 2025

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

RE: CCN: 245572
Cycle Start Date: November 21, 2024

Dear Administrator:

On December 13, 2024, we informed you that we may impose enforcement remedies.

On January 23, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K0321 - Hazardous Areas - Enclosure - Bld 01
K0914 - Electrical Systems - Maintenance And Testing - Bld 01
K0914 - Electrical Systems - Maintenance And Testing - Bld 02

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 21, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 21, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 21, 2025.

You should notify all Medicare/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 admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 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 \$12,924, 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 February 21, 2025, 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 February 21, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC 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.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to

Colonial Manor Nursing Home

January 27, 2025

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being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

PRINTED: 01/31/2025
FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/30/2025

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: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321}	Continued From page 1 by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 321}	On January 27,2025 ESD applied additional caulking to file room . File room opening was sealed using fire-rated caulking materials approved by NFPA; ESD determine compliance with NFPA 101 Life Safety Code standards. ESD received additional training on NFPA 101 fire safety standards, including identifying and sealing penetrations in fire-rated walls. Colonial Manor will be in compliance by Jan 27, 2025		
{K 914} SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	{K 914}			1/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 914}	Continued From page 2 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 914}	On January 28, 2025 ESD finalized all electrical receptacles testing. Updated and maintain a written record of the risk assessment, including findings, corrective actions taken, and recommendations for future improvements. Will ensure this documentation is readily available for inspection by regulatory agencies. Colonial Manor will be in compliance by Jan 28,2025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	{K 000}			
{K 914} SS=F	Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey. Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 914}		1/28/25	
			On January 28, 2025 ESD finalized all electrical receptacles testing. Updated and maintain a written record of the risk assessment, including findings, corrective actions taken, and recommendations for future improvements. Will ensure this		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/30/2025

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: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED R 01/23/2025
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 914}	Continued From page 1	{K 914}	documentation is readily available for inspection by regulatory agencies. Colonial Manor will be in compliance by Jan 28,2025		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2024

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

RE: CCN: 245572
Cycle Start Date: November 21, 2024

Dear Administrator:

On November 21, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC 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.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 21, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by May 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Colonial Manor Nursing Home

December 13, 2024

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A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 12/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments On 11/18/24, to 11/21/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 11/18/24, to 11/21/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55721371C (MN108283), H55721375C (MN107795), H55721394C (MN108343), H55721500C (MN108338). The following complaint was reviewed: H55721374C (MN102179) and a deficient practice was identified at F609 related to incidental finding. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/23/2024

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.

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F 000	Continued From page 1	F 000			
F 585 SS=D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585			1/10/25

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F 585	Continued From page 2 facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions			F 585			

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F 585	Continued From page 3 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 resident (R19) who reported missing property. Findings include: R19's significant change Minimum Data Set (MDS) assessment dated 10/2/24, identified R19 had moderately impaired cognition. On interview 11/18/24 at 1:54 p.m., R19 stated he has had multiple packs of handkerchiefs lost when sent to laundry along with a couple shirts since his admission to the facility January 2024. R19 stated he is not sure how many	F 585	Upon identification of the R19 expressing missing items of clothing, facility staff visited with resident regarding these items, completed a missing item and grievance form due to the lack of response time prior. The facility has agreed to reimburse the resident for the expense of his missing items. Identified grievances regarding missing or damaged resident items were promptly investigated, resolved, and communicated to the affected resident(s). This alleged deficient practice has the potential to impact all residents. An audit		

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F 585	Continued From page 4 handkerchiefs come in a pack but he has told multiple staff about his missing items. On interview 11/20/24 at 9:41 a.m., nursing assistant (NA)-A stated when residents inform them of missing belongings including clothing, would tell the charge nurse. NA-A was unsure what happens after that. On interview 11/20/24, at 9:45 a.m., NA-B stated staff fill out a missing belonging sheet and inform the charge nurse of the missing belongings. NA-B added they also put the form in the binder at the nurse's station. On interview 11/20/24 at 9:45 a.m., the nursing department coordinator (NDC)-A stated there was no book of missing belongings at the nurses station. NDC-A was able to locate a form to complete for missing or damaged items but thinks they are turned into social services to follow-up on and file. On interview 11/20/24 at 9:48 a.m., registered nurse (RN)-A, stated social services would have the missing belongings binder with the completed forms. RN-A indicated they currently do not have a social worker and she would look for them in her office. On interview 11/20/24 at 9:54 a.m., R19 stated "every time I get new hankies, they just disappear in laundry". R19 stated his wife just got him a new pack and he is already down to 1 or 2 of them. R19 also indicated he has told staff multiple times about them missing along with his shirts. On interview 11/20/24 at 10:24 a.m., laundry	F 585	of grievances filed within the past 30 days was conducted to identify unresolved or improperly addressed grievances, particularly those involving missing or damaged personal items. All staff received training on 12/10/2024 on grievance policy, emphasizing the importance of timely resolution and ongoing communication with residents and or family. The designated grievance officer will be responsible for tracking grievances and ensuring follow-ups are completed timely. Visual aids summarizing grievance procedures will be displayed in the staff lounge. The Social Services Director will audit the grievance log. The audits will be conducted for 3 months to ensure all grievances are appropriately documented, addressed, and resolved. Grievance log will be reviewed monthly during QA meetings for 3 months or until resolved compliance. Colonial Manor will be in compliance by Jan 10, 2025.		

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F 585	Continued From page 5 (L)-D indicated she has been aware of R19's missing handkerchiefs for the last month or two but not of his shirts. L-D stated they have looked for the missing handkerchiefs but have not been able to locate them. L-D indicated social services follows up with the residents. On interview 11/20/24 at 4:08 p.m., the administrator stated social services does keep a binder of missing belongings forms, but there was no form for R19's missing shirts or handkerchiefs present. The administrator confirmed a missing belongings form should have been completed and the grievance process was not followed through. The administrator stated "any missing belonging is a big thing". Facility Missing or Damaged Items policy dated 2/19, included: - Person told of missing item to gather as much information as possible and initiate search for item. - If item is not found, complete the Missing or Damaged Item report form, and report it to charge nurse. - Charge nurse to determine further action in attempts to locate missing item and notify other departments as necessary. - Original copy of missing or damaged item report to be given to Social Services. - Social Services maintains file of all pertinent information regarding missing or damaged items.	F 585			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		1/10/25	

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F 609	Continued From page 6 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported to the administrator and the State Agency (SA) timely for 1 of 1 resident (R24) reviewed for allegations of abuse. Findings include: Review of the 11/13/24 at 10:50 a.m., report to the SA identified on 11/12/24, at 6:15 a.m., resident informed staff the nursing assistant stated "You better start cooperating with me or "I			F 609	F609 Reporting of Alleged Violations The alleged deficiency was reported and has been resolved. Resident R24 was assessed immediately upon learning of the deficiency to ensure their safety and well-being. The alleged perpetrator was removed from the facility to prevent contact with R24 until the investigation was completed. Family members and/or the responsible party for R24 were notified.		

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F 609	Continued From page 7 will tell your husband and he will yell at you" and "You better be nice or your husband will yell at you". On interview 11/18/24 at 1:47 p.m., R24 denied any recent alleged events with verbal abuse. On interview 11/18/24 at 4:46 p.m., family member (FM)-A stated the facility did notify her regarding an event that occurred last week sometime (unable to identify the date) with potential verbal abuse. FM-A indicated R24's memory is very poor and would not recall any events from the past week. On interview 11/19/24 at 9:58 a.m., the director of nursing (DON) indicated she was notified of the alleged abuse event on 11/13/24 regarding R24, and reported it that same morning. The DON confirmed the event occurred 11/12/24. On interview 11/19/24 at 11:32 a.m., nursing assistant (NA)-C stated she was working on 11/12/24 around 6:00 a.m., when NA-D came into the room to assist and told R24 he was going to tell her husband who will yell at her. NA-C stated she thought about the encounter through the day and around 1:30 p.m. discussed the event with her co-workers who informed her she needed to report the event to the charge nurse. NA-C indicated the charge nurse was not available, and the DON and administrator were not present at the facility so she notified the business office manager (BOM)-G around 2:30 p.m. On interview 11/20/24 at 10:36 a.m., the administrator confirmed the alleged event report was not made to the SA until the following day. The administrator stated she was out of the	F 609	All other residents could be impacted by this deficient practice. The facility reviewed prior month (30 Days) FRI reports with no deficient timely reporting found. The abuse reporting policy was reviewed with no changes. All staff received re-education on 12/10/2024 on Colonial Manor's policy regarding reporting abuse and neglect. Staff were assigned Relias Computer Module training: Abuse, Neglect, and exploitation; Abuse: Preventing, Recognizing, and Reporting to be completed on 12/18/2024. The Social Service Director, DON, and Administrator also attended a Risk Management Workshop on 12/16/2024. The administrator or designee will audit all FRI's monthly x3 months to ensure timely reporting. Results of the audit will be reviewed monthly during QA meetings for 3 months or until resolved. Colonial Manor will be in compliance by Jan 10, 2025.		

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F 609	Continued From page 8 building the day of the alleged event and during investigation found out the event occurred in the morning but wasn't reported until later in the day from the staff member internally. The administrator stated she received notification from BOM-G on 11/12/24, in the afternoon and instructed her to have the DON report the event but she was out of the office also. The administrator attempted to get another staff member privileges to report to the SA but was unsuccessful so event wasn't reported until the next day by the DON.	F 609			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a residents hospice status was accurately coded on the Minimum Data Set	F 641	On 11/20/2024 upon identification of R15's MDS assessment section O findings, the MDS coordinator completed		1/10/25

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F 641	Continued From page 9 (MDS) assessment for 1 of 1 residents (R15) reviewed for hospice and end of life. Findings include: R15's facesheet printed on 11/20/24, included diagnoses of protein-calorie malnutrition and encounter for palliative care. R15's current, quarterly MDS assessment dated 10/15/24, indicated R15 had moderately impaired cognition, had clear speech, could understand, and be understood. Hospice was not marked on the MDS. R15's significant change MDS assessment dated 7/5/24, indicated R15 was receiving hospice care. A progress note dated 7/3/24, indicated the provider faxed an order requesting hospice admission. During a telephone interview on 11/20/24 at 9:29 a.m., hospice agency administrative assistant (AD)-F stated R15 was enrolled in hospice on 7/8/24. R15's certification of terminal illness (CTI) diagnosis was protein calorie malnutrition. During an interview on 11/20/24 at 9:54 a.m., registered nurse (RN)-A who was also the MDS nurse, looked in R15's electronic medical record (EMR) and acknowledged hospice was not marked in Section O which indicated special treatments, procedures, and programs, for the quarterly MDS assessment dated 10/15/24. RN-A immediately made a modification to add hospice to R15's MDS and stated she inadvertently missed that.	F 641	a modification to R15's assessment. The MDS Coordinator reviewed all residents MDS assessments that are currently receiving Hospice services to ensure coding was in compliance. No findings of Section O inaccuracies were found at this time. MDS Coordinator was educated on regarding the coding of Hospice in section O. Facility continues to utilize Pathway services in auditing of MDS's assessments for accuracy. Regional Director will audit any newly admitted hospice residents for 3 months to ensure accurate coding of Hospice in section O. All audits will be reviewed at QA for 3 months or until resolved. Colonial Manor will be in compliance by Jan 10, 2025.		

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F 641	Continued From page 10	F 641			
F 657 SS=D	Facility policy for accuracy of MDS assessments was requested and not received. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan was revised to include hospice care for 1 of 1 residents (R15) reviewed for hospice and end of life.	F 657	Upon identification of the R15's care plan not accurately reflecting hospice services, MDS Coordinator updated the care plan. R15 was receiving Hospice		1/10/25

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F 657	Continued From page 11 Findings include: R15's facesheet printed on 11/20/24, included diagnoses of protein-calorie malnutrition and encounter for palliative care. R15's quarterly Minimum Data Set (MDS) assessment dated 10/15/24, indicated R15 had moderately impaired cognition, had clear speech, could understand, and be understood. R15's progress notes dated 7/3/24, indicated the provider faxed an order requesting hospice admission. R15's care plan initiated on 5/1/23, had no reference to R15 receiving hospice or palliative care. During a telephone interview on 11/20/24 at 9:29 a.m., hospice agency administrative assistant (AD)-F stated R15 was enrolled in hospice services on 7/8/24. During an interview on 11/20/24 at 9:54 a.m., registered nurse (RN)-A who was also the MDS nurse, stated if a resident was receiving hospice services, it would be identified on his/her care plan. RN-A looked in R15's electronic medical record (EMR) and acknowledged neither hospice or palliative care was identified on the care plan. RN-A stated either she or the director of nursing could add updates to the care plan, as well as any nurse. RN-A stated she should have caught that omission. Facility Care Planning policy with revised date of 8/23, indicated the care planning process began	F 657	services since the admission to hospice. All other residents currently on Hospice services were reviewed and updated by the MDS Coordinator to ensure care plan reflected the hospice services they are receiving. MDS Coordinator was educated on care planning and the need to identify hospice services on the care plan. DON or designee will audit any newly admitted hospice residents for 3 months to ensure any admitted hospice residents have hospice services addressed on the plan of care. All audits will be shared and reviewed at QA for 3 months to assess for the need of ongoing monitoring. Colonial Manor will be in compliance by Jan 10, 2025.		

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F 657	Continued From page 12 pre-admission and continued on a regular and periodic basis throughout the residents stay. Care plans were updated with any changes.	F 657			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to document a complete recapitulation of	F 661			1/10/25
			The facility went back to R28's medical record and completed to the best of their		

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F 661	Continued From page 13 stay for 1 of 1 resident (R28) reviewed for discharge. Findings include: R28's facesheet printed 11/20/24, identified an admission date to facility of 7/8/24 with diagnoses including: pressure ulcer of left foot (bedsore injury to the skin and tissue below the skin), depression, osteomyelitis (infection in bone) and paraplegia (paralysis that mostly affects the movement of the lower body). R28's discharge orders were dated 10/24/24, and signed by the provider. A progress note dated 10/25/24 at 9:51 a.m., by registered nurse (RN)-B included resident discharged to home with wife. Personal belongings, over the counter medication were taken home. Discharge orders reviewed with wife and resident and they state understanding. The medical record lacked a discharge summary. On interview 11/20/24 at 4:43 p.m., registered nurse (RN)-H, also identified as regional director of skilled care, confirmed she was not able to locate a discharge summary in the medical record and added there has been a turn over in staff so was unsure if it was completed but it should have been. On interview 11/20/24 at 4:47 p.m., RN-A, also identified as MDS coordinator, stated in the past social services was responsible for the discharge process and this was her first time doing a discharge. RN-A stated she was not aware she needed to fill out a discharge summary so this	F 661	ability a complete discharge summary. All other discharges in the last 30 days were reviewed to assure a completed discharge summary. In order to ensure the discharges going forward have a more complete discharge summary, the facility has implemented the required use of the Discharge summary tab in Matrix Care. Policy has been reviewed and updated, along with education to the leadership team that can open the discharge summary. Any other discharges in the past month have been reviewed and a more complete discharge summary will be completed. The Regional Director will audit all discharges for the next 3 months to assure that the discharge summary in Matrix is completed. All audits will be shared and reviewed with the QA committee to determine compliance or the need for ongoing monitoring. Colonial Manor will be in compliance by January 10, 2024		

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F 661	Continued From page 14 was not done but did send the orders with the resident upon discharge. Facility Death/Discharge Record Completion policy dated 8/23/24, included: On permanent discharge, nursing will complete discharge summary to the extent possible in the electronic health record (EHR). On permanent discharge, nursing will secure the signature and address of the responsible person to whom released, the signature and address of the resident. The signature and address is recorded on the admission and discharge record. The nurse will complete the discharge summary in the EHR. The physician will be notified via fax, phone call or in person of discharge.	F 661			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692			1/10/25

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F 692	Continued From page 15 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document and monitor weight loss for 1 of 1 resident (R24) who had weight loss. In addition, the facility failed to obtain accurate weights for 2 of 2 residents (R24, R4) who were evaluated for nutrition. Findings include: R24's facesheet printed on 11/20/24, included diagnoses of stroke affecting left side, Parkinsonism (movement related disorder), dementia, mild with anxiety, hypoglycemia (low blood sugar), hyponatremia (low sodium level), and dysphagia (difficulty swallowing). R24's quarterly Minimum Data Set (MDS) assessment dated 7/15/24, indicated R24 had severe cognitive impairment, required setup help for eating and was dependent for transfers, mobility in wheelchair, dressing, and personal cares of activities of daily living (ADL's). No weight loss or gain. R24's care plan dated 10/23/24, indicated R24 was at risk for nutritional compromise related to right sided stroke and Parkinson's disease. Goals included resident will have adequate intakes of food and fluids with meals/snacks and resident will not have triggered weight loss of 5% in 30 days or 10% in 180 days. Interventions included allow resident to make meal choices, offer extra fluids between meals for hydration at activities and in common areas and room, resident will maintain ability to feed self, monitor	F 692	Upon identification of weight discrepancies, RD reviewed R24's chart suggesting a supplement. MD was contacted on 11/20 re: current weight and meal intakes and requested a supplement for R24; MD ordered boost TID. A care conference was held with the Interim DON, Case Manager, Social worker, Hospice Social Worker, Administrator, R24 husband, and/or the R24 representative to review the weight loss and develop a plan. 12/16 Care Plan updated to included: Assistance with meals. Re-weigh of R24 was conducted using calibrated equipment to confirm current weight on 12/19. 12/17 order was put in for weekly weights will be documented and monitored for the next 4 weeks, then monthly if stable. x2 Months. R24 was admitted to hospice on 11/27 per provider orders and family consent. The Identification of R24 weight loss also prompted ESD to recalibrate all scales due to inaccurate weight fluctuations noted. Nursing orders placed to ensure correct report/weight being obtained RD reveiwed R4 chart on 11/18 and 12/3 per routine monitoring since admission. A re-weigh was conducted on to confirm the current weight. The interdisciplinary team evaluate R4's nutritional needs to determine if additional interventions are required. R4 was receiving a supplment. Facility offered resident's representative		

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F 692	Continued From page 16 monthly weights for any significant trigger, weigh and notify provider of weight changes per facility protocol. Additional interventions included monitor and record intakes of food and fluids, observe for any problems with chewing or swallowing and work with speech therapy for safest level of chewing and/or swallowing. R24's physician orders dated 7/18/24, indicated R24's diet included regular with cut up meats at meals, thin liquids. A nurse progress note dated 11/13/24 at 1:25 p.m., by licensed practical nurse (LPN)-B included provider here for house rounds and orders for speech therapy to evaluate for increased complaints of swallowing issues. A nurse progress note dated 11/18/24 at 6:49 p.m., by LPN-A included R24 has had a diet change: Soft and bite size recommended and take a sip of water after each bite to ensure food is fully chewed and swallowed. Crush all pills, and thin liquids as ordered by speech therapy. R24 weights in pounds recorded since admission on 5/10/24 included: 5/11/24 - 146.2 6/13/24 - 147.4 7/11/24 - 151.4 7/29/24 - 184.8 8/5/24 - 141.0 9/5/24 - 184.8 9/5/24 - 194 9/27/24 - 142.2 10/14/24 - 140.2 11/4/24 - 135.2 11/11/24 - 123 11/14/24 - 121 - 17.24% change from admission			F 692	assistance with getting PEGtube placement. Family declined ☐ facilities ☐ offer to support assistance in arranging services. On 12/18 R4 had appt for peg tube placement upon later agreeing. R4 was admitted to hospital during placment and has since expired at the hospital. 12/17 an order was put in for weekly weights to be monitored for the next 4 weeks, then monthly if stable. x2 Months. All residents could potentially be impacted by the deficient practice. All residents were re-weighed with new orders to ensure routine weights per facility reviewed policy. The facility ☐s policy on Weights and weight changes of residents ☐ was reviewed and updated. The RD will meet with DON or designee and dietary weekly. Daily morning IDT communication sheet was updated to reflect weight changes. Education was provided to nursing staff on 12/10/2024 regarding the need to obtain weights and identify weight changes. Relias training was assigned to nursing department staff Titled: Diets More than just weight loss; Obtaining an individuals height and weight. The ESD will calibrate scales on a weekly basis to identify any discrepancies. Regional Quality Nurse will audit residents ☐ weights weekly for 3 months to ensure compliance. All audits and calibration reports will be reviewed at QA for 3 months or until		

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F 692	Continued From page 17 6 months prior. 10.5 percent change from 11/4/24. On interview 11/18/24 at 4:54 p.m., family member (FM)-A stated R24 has not had an appetite lately and will take bites and spit it out. FM-A indicated she was not aware of a weight loss but FM-B had informed her she isn't eating much if at all. During observation on 11/18/24 at 6:30 p.m., R24 was eating in her room with husband present. Ate 50% of her meal. During observation on 11/19/24 at 12:45 p.m., R24 refused her lunch. Review of meals documented from 10/20/24 to 11/19/24 included: None: 11 times 0-25%: 7 times 26-50%: 11 times 51-75%: 12 times 76-100%: 24 times A nutritional assessment dated 11/12/24, observation and completion date by registered dietician (RD)-I, included a score of 10 indicating R24 is at risk of malnutrition. Notes included: R24 has had variations to weights and it appears some are inaccurate. She was readmitted with stroke and history of Parkinson's Disease. Admission height taken from hospital records 65" and weight 146 pounds. Ideal body weight is 125 pounds. Estimated nutritional needs 1300-1500 calories, 60-70 grams protein and 1600 ml fluids. Review weight 135 pounds which is a decrease of 3.5% in 30 days and a decrease of 7.5% in 180 days. Both do not trigger for weight loss. Diet is	F 692	resolved. Colonial Manor will be in compliance by Jan 10, 2025.		

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F 692	Continued From page 18 regular, regular texture (cut up) and regular liquids. Intakes are generally adequate with small portions preferred. Her husband comes to feed her meals which are consumed in room for most part. Her husband brings her a donut for mid - morning snack. She has her own teeth and there are no problems with chewing or swallowing at present. Nursing notes that she had difficulty swallowing on 10/4/24, however this was also associated with anxiety and difficulty breathing. No other notes regarding problems. Medications pertinent to nutrition include laxatives with many medications recently discontinued. Mini Nutritional Assessment score: 9 - at nutrition risk NUTRITION DIAGNOSIS Inability to manage self care and physical inactivity related to stroke and Parkinson's disease as evidenced by requiring assistance with ADL's and structured meals to maintain nutrition status. NUTRITION INTERVENTIONS: Diet: regular, regular texture and regular liquids Cut up meat for ease of self feeding NUTRITION PLANS: Provide diet as ordered Snacks per facility protocol and resident preferences Monitor any difficulty with swallowing Monitor need for nutrition supplement if weights are accurately declining. Monitor intakes of food/fluids to ensure nutrition needs are being met. On interview 11/20/24 at 3:06 p.m., the registered dietician (RD)-I stated she has had issues with getting accurate weights or reweighs completed when requested. RD-I stated when she completed her recent nutritional assessment it			F 692			

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F 692	Continued From page 19 was for the look back period dating from previous quarterly assessment 7/15/24 through 11/7/24. RD-I indicated if the weights for 11/12 and 11/14 were accurate, she should have been notified of the significant weight loss. RD-I indicated it has been difficult to complete accurate assessments when weights are sometimes inaccurate. RD-I stated she has requested re-weights but they are never completed. RD-I indicated she writes possible inaccuracy of weights in her reports which go to all the department heads, so they are aware of the request for re-weights and possible inaccuracy of weights. On interview 11/20/24 at 3:16 p.m., licensed practical nurse (LPN)-A reviewed R24's weights and stated there are obvious operator errors present and R24 should have been reweighed with the inaccurate weights that struck out as errors. LPN-A added he has requested a lot of reweighs at the facility due to "crazy" weight difference since he has been at the facility at the end of September. LPN-A stated the most recent weight from 135 to 123 pounds in one week would require notification to the physician. LPN-A added R24 hasn't been eating much so the weights could be accurate. LPN-A reviewed the record and confirmed there is no documentation present of physician notification of the significant weight change. On interview 11/20/24 at 3:25 p.m. interim case manager (ICM)-K confirmed a 12 pound weight loss in one week is a significant weight loss and the physician should have been notified. ICM-K indicated weights that are obviously not accurate need to be reweighed and inaccurate weights struck out as error.	F 692			

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F 692	Continued From page 20 On interview 11/20/24 at 3:29 p.m., nurse consultant (NC)-L confirmed the facility has had issues with the monitoring and accuracy of weights and it is on a list to address. On interview 11/20/24 at 3:32 p.m., the dietary manager (DM)-J indicated she has met with R24 and FM-B regarding her intake and snacks. DM-J indicated she has observed FM-B eating portions of R24's food so is not sure how accurate the intake documentation is. DM-J confirmed she has had difficulty getting accurate weights with some weights being obvious significant errors. When reweighs are requested, they don't happen. DM-J confirmed she, the RD and the physician should have been notified of R24's recent significant weight loss. R4's facesheet printed on 11/20/24, included diagnoses of severe protein-calorie malnutrition and dysphagia (difficulty swallowing). R4's quarterly Minimum Data Set (MDS) dated 9/6/24, indicated R4 was cognitively intact and was dependent upon staff for activities of daily living (ADL's). R4's orders did not specify obtaining measured weights. R4's care plan with revised date of 10/2/24, indicated R4 was at nutrition risk due to history of poor intake and history of requiring a feeding tube. In addition, staff were to monitor monthly weights for significant changes, notify the provider of weight changes per policy, and to weigh R4 per facility protocol or provider orders. Review of R4's weights showed weights consistently over 100 pounds from 8/16/24, to	F 692			

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F 692	Continued From page 21 10/16/24, except for an aberrant weight on 9/30/24, of 82.6 pounds. Review of dietician progress notes indicated: --10/1/24: Weight listed in the EMR (electronic medical record) on 9/30/24, is 82.6 # (pounds). Question the accuracy of this. --10/15/24: Weights appear inaccurate with weight on 9/16/24, 107# and weight on 9/30/24, of 82.6 #. During a telephone interview on 11/19/24 at 9:52 a.m., registered dietician (RD)-I stated she suspected some inaccurate resident weights but had not spoken to the nursing staff or director of nursing (DON) about it. RD-I stated she included this information in her nutrition reports which went to department leaders, so they were aware of the possible inaccuracies of weights. During an interview on 11/19/24, at 11:20 a.m., the DON stated she was aware of inaccuracies of weights; that it has been identified one or two months ago. The DON stated because of this, staff re-weighed resident wheelchairs and updated the wheelchair weight book. The DON stated she had then asked nurses to obtain residents weights rather than nursing assistants (NA's). The DON stated she would look for the written communication to the nurses regarding this change, but she used mostly verbal communication to inform them. During an interview on 11/19/24 at 12:27 p.m., licensed practical nurse (LPN)-B stated had not received communication from the DON indicating only nurses should be weighing residents. LPN-B stated she was aware of weight inaccuracies, adding a physician, "Got after me about that one	F 692			

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F 692	Continued From page 22 day." LPN-B stated each day she wrote in a small notebook which residents needed a measured weight. After a NA obtained the weight, the NA recorded it in the notebook, then LPN-B calculated the weight without the wheelchair and entered it into the EMR. While she had not seen evidence of it, LPN-B stated she wondered if NA's were weighing residents in a wheelchair with the oxygen tank attached, adding that could account for the weight fluctuations. During an interview on 11/20/24 at 8:56 a.m., the administrator was aware of inaccurate weights being recorded in resident records. The administrator stated the inaccuracies were sometimes due to staff not waiting for the scale to be fully turned on and therefore the weight was skewed. The administrator stated the maintenance director had calibrated the scale and the DON provided education to the nursing staff. The administrator stated she would look for the documentation of the education and stated it did not indicate (as the DON had stated), that only nurses would weigh residents rather than NA's. During an interview on 11/21/24, at 8:41 a.m., in the shower room with the wheelchair scale, NA-H stated NA's weighed a residents in their wheelchair, then gave the charge nurse the weight. NA-H stated she thought the nurse deducted the wheelchair weight. Observed a sign on the scale indicating to remove the oxygen tank [before weighing the resident]. During an interview on 11/21/24 at 9:16 a.m., LPN-B stated she got sick of inaccurate weights one weekend, so created a list of the weight of resident wheelchairs so that nurses could use	F 692			

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F 692	Continued From page 23 that information when calculating weights. LPN-B stated she shared the list with the nursing staff and made the DON aware too. During an interview on 11/21/24 at 9:19 a.m., nursing assistant (NA)-F stated residents were weighed in the shower room. If a resident had an oxygen tank on their wheelchair, that was removed. NA-F stated she gave the total weight measurement (resident and wheelchair) to the nurse who wrote it down, but NA-F didn't know what happened after that. Facility Weighing and Weight Changes of Residents policy dated 4/22, included weekly weights are taken by nursing staff and entered into the electronic medical record. The DM or RN/LPN will review weights and request for reweighs if there is a change of plus or minus 3 pounds in a week. If reweigh confirms a weight change of 3 pounds gain or loss, daily weights will be requested by RN/LPN or DM for 7 days to observe resident's weight. The DM will evaluate for significant weight gains and losses. If significant weight charges are documented, the DM will report to the RD to review. If weight loss is confirmed and the resident's meal intakes are more than 50%, the DM will report to the RD and provider with confirmation of significant weight change. The DM will continue to observe resident's weight for another week before starting interventions, unless recommended to do otherwise by RD or provider. If weight loss is confirmed and the resident's meal intakes are less than 24-50%, the DM will report to the RD and provider with confirmed weight loss. The DM will start interventions as stated in the nutrition at risk policy and procedure.	F 692			

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F 801 F 801 SS=F	Continued From page 24 Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the	F 801 F 801			1/10/25

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F 801	Continued From page 25 requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and			F 801			

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F 801	Continued From page 26 (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietitian (RD), the dietary manager (DM) was certified to oversee nutrition and food services. This had potential to affect all 25 residents who resided in the facility. Findings include: During an interview on 11/18/24 at 12:25 p.m., dietary manager (DM)-J stated she had been employed at the facility since 12/18/23 and was not a certified dietary manager nor had she started any classes. DM-J stated she was notified today the administrator was going to get her signed up for the certification class. DM-J stated she does have a Food Safety Certificate, which she completed in 2019. During an interview on 11/20/24 at 10:45 a.m., the administrator was aware DM-D was not certified as a dietary manager. The administrator stated she understood the registered dietitian coming once a week would be adequate until DM-J got her certification. The administrator stated, "DM-J has not been signed up for her dietary certification classes". Dietary manager job description undated, skills/qualifications included, knowledge of state and federal food regulations, Serv-Safe Certified, current certification as a Certified Dietary Manager (CDM) or dietitian preferred or willing. If not licensed as CDM will encourage the			F 801	No residents were directly impacted by the deficient practice. The Dietary Manager has enrolled in the University of North Dakota Certified Dietary Manager program to work towards the CDM certification. The Facility Dietary Manager will also complete the MN Certified Food Manager Protection course and application to the state 12/27/2024, this meets the requirement of 483. 60(a)(2) section E (ii). The consulting Registered Dietitian will meet with dietary manager on a weekly basis and summarize her visits and provide the visit summary to the Administrator. Administrator will monitor the progression of the course to ensure timely completion. Job description reviewed and updated. QA will review and recommend if further action is needed. Colonial Manor will be in compliance by January 10, 2024		

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F 801	Continued From page 27	F 801			
F 851	candidate to get obtain their CDM certificate.	F 851			
SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and				1/6/25

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F 851	Continued From page 28 tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 3, 2024), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: The CMS payroll-based journal (PBJ) staffing data report for quarter 3 of 2024, which included dates from 4/1/24, to 6/30/24, triggered for: Four	F 851	It is the practice of Colonial Manor to electronically submit accurate direct care staffing information each quarter. No residents were identified as being at risk for not submitting accurate Payroll Based Journal data, due to nurse coverage at all times during the reported quarter. In reviewing the dates triggered, Colonial Manor reviewed the dates where unidentified nursing hours were. It was identified that agency nursing hours were missed being input to the system. In order to ensure that Colonial Manor		

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F 851	Continued From page 29 or More Days Within the Quarter with <24 Hours/Day Licensed Nursing Coverage. The following infraction dates were identified: 5/25/24, 6/8/24, 6/9/24, 6/16/24, 6/1/24, 6/22/24, 6/23/24, 6/24/24, 6/29/24, and 6/30/24. Review of nursing staff schedules for each infraction date indicated a licensed nurse had been scheduled each of the three shifts (days, evenings, and nights). The daily staffing postings for each infraction date indicated a licensed nurse was scheduled on each shift. During an interview on 11/20/24 at 11:10 a.m., nursing department coordinator (NDC)-A who was responsible for scheduling nursing staff, stated there was always a licensed nurse working every day, on each shift - days, evenings, and nights. Together with business office manager (BOM)-G, timecards were reviewed for each infraction date. All shifts were identified as having been worked by a licensed nurse, either an employed nurse or an agency nurse. During an interview on 11/20/24 at 3:15 p.m., BOM-G stated she was responsible for entering data for the PBJ report and was not able to identify why the report triggered for four or more days within the quarter with <24 hours/day licensed nursing coverage. All nursing staff, including management and/or agency were entered into the report. During an interview on 10/20/24 at 4:00 p.m., the administer could not determine the reason the PBJ report triggered for four or more days within the quarter with <24 hours/day licensed nursing	F 851	submits accurate data the BOM and Regional Director will review licensed nursing hours to assure for accurate reporting of nurse coverage required in the SNF. The BOM will input hours on a more frequent basis to account for more frequent reviews before submission. Regional Director will audit the next 2 quarters of hours, review and discuss audit findings with BOM and share audits with the QA committee meeting. The QA committee to determine the need for on-going monitoring. Colonial Manor will be in compliance by 1/6/2024		

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F 851	Continued From page 30 coverage.	F 851			
F 880 SS=D	Facility PBJ policy was requested, and the administrator stated the facility followed the CMS PBJ - LTC (long term care) policy manual. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880			1/10/25

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F 880	Continued From page 31 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R26) who had a urinary ostomy	F 880			
			Conducted an immediate assessment of R26 to ensure no harm resulted from the lack of EBP. Reviewed care plan to include proper infection control measures.		

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F 880	Continued From page 32 Findings include: R26's facesheet printed on 11/20/24, included diagnoses of neuromuscular dysfunction of the bladder (when the nerves and muscles that control the bladder don't work properly), bladder-neck obstruction, and a urinary diversion device - a urinary ostomy (an opening in the abdominal wall to redirect the urine). R26's admission Minimum Data Set (MDS) assessment dated 11/4/24, indicated R26 had moderately impaired cognition, clear speech, could understand and be understood. R26, who didn't walk, required staff assistance for most activities of daily living (ADL's), including toileting. R26's physician order dated 11/5/24, indicated to change two-piece urostomy pouch on Tuesday and Friday if leaking. During an observation on 11/19/24 at 1:20 p.m., observed an EBP sign hanging on R26's door which indicated staff were to don personal protective equipment (PPE) including gown, gloves, and mask, prior to providing care. Nursing assistant (NA)-F was observed taking a sit-to-stand mechanical lift into R26's room without donning PPE. NA-F assisted R26 from wheelchair to mechanical lift to toilet without PPE, then exited the room. During an observation and interview on 11/19/24 at 1:40 p.m., NA-F donned PPE - gown, gloves, and mask - to enter R26's room. NA-F stated she didn't don PPE to take R26 into the bathroom and assist him onto the toilet because she didn't touch him during that process.	F 880	Enhanced Precautions Implemented: Initiated appropriate EBP for R26, including proper use of personal protective equipment (PPE) during care of the urinary ostomy. Staff Education and Compliance Check: Verified compliance of all staff providing care to R26 with EBP guidelines. Corrective coaching was provided where necessary. The staff member involved was immediately re-educated on the proper donning of PPE before entering the resident's room under enhanced barrier precautions. The resident's care plan was reviewed to ensure all staff are aware of the precautions, and the room was sanitized to mitigate potential risks. This alleged deficient practice has the potential to impact all residents on enhanced barrier precautions. A facility-wide audit was conducted to verify compliance with PPE protocols for all such residents and identify any similar lapses. All staff received education on 12/10/2024 and were assigned Relias training on: PPE-Donning and Doffing. Regular audits will be conducted to ensure staff are following EBP policy. Policy was reviewed with no changes noted. A weekly audit will be conducted for 3 months to observe staff compliance with PPE use when entering rooms of		

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F 880	Continued From page 33 During an interview on 11/19/24 at 1:54 p.m., along with NA-F reviewed the EBP sign on the outside of R26's door. NA-F admitted she didn't wear PPE when toileting R26 with the sit-to-stand mechanical lift, adding, "It's a fine line -- I can put the sling [for the lift] on him without touching him." During an interview on 11/19/24 at 1:58 p.m., the director of nursing (DON) stated whether or not staff donned PPE to care for a resident in EBP depended on the "distance." When asked if there was a distance requirement, the DON stated would need to look at the policy. During an interview on 11/19/24 at 2:03 p.m., the DON provided the EBP policy and stated according to the policy, staff should wear PPE when toileting a resident in EBP. During an interview on 11/19/24 at 4:22 p.m., registered nurse (RN)-A, who was also the infection preventionist, stated nursing staff had a meeting on 11/11/24, where EBP was reviewed. A copy of sign-in sheet was provided and NA-F's signature was listed. Facility Enhanced Barrier Precautions policy with revised date of 6/21/24, indicated EBP was used with residents who had indwelling medical devices; that an indwelling medical device provided a pathway for pathogens in the environment to enter the body and cause infection. EBP was used when performing high contact resident care activities such as toileting.	F 880	residents on enhanced barrier precautions. Audit results will be reviewed during monthly QA meetings, and further training will be provided as needed. Colonial Manor will be in compliance on 1/10/2024		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881			1/10/25

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F 881	Continued From page 34 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance for 4 of 5 residents (R9, R19, R20, R25) reviewed for antibiotics. This had the potential to affect any of the 25 residents who resided in the facility who might use antibiotics. Findings include: Review of the monthly infection control log dated 7/2024, 8/2024, 9/2024, 10/2024 and 11/2024, identified residents who had been identified as having an infection and had been administered an antibiotic and had included the floor plan of the facility. Review of 7/2024, surveillance log identified R20 had a urinary tract infection (UTI). R20 was admitted February 2024. R20's face sheet had diagnoses of dementia with anxiety and traumatic brain injury. She was prescribed an antibiotic Macrobid that was started on 7/28/24. The surveillance log lacked indication of the antibiotic dosages and when or if the infection had resolved.	F 881	A retrospective review of antibiotic use for residents R9, R19, R20, and R25 was conducted to determine appropriateness of indications, dosage, and duration. Any discrepancies identified were addressed to the prescribing provider. IDT meeting tracking and monitoring, antibiotic use in addition to any necessary changes in treatment. No adverse events or harm were identified as a result of improper antibiotic use during this review. This alleged deficient practice has the potential to impact all residents. A comprehensive audit of antibiotic use for the past 6 months will be conducted to assess indications, dosages, and durations of use for all residents. Staff education will include training on the antibiotic stewardship program. Education will be provided to IP to include proper review of indications, dosages, and durations, as well as the tracking of antibiotic use. The morning IDT clinical review will reflect any new orders.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2024	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 881	Continued From page 35 Review of 9/2024, surveillance log identified R19 had a UTI infection. R19 was admitted January 2024. R19's face sheet had diagnoses of dementia, UTI, obstructive reflux uropathy and benign prostatic hyperplasia (enlargement) with lower urinary tract symptoms. R19's 10/02/24, significant change Minimum Data Set (MDS) identified he had an indwelling catheter. R19 was prescribed an antibiotic ampicillin 500 milligrams (mg) on 9/16/24. The surveillance log lacked indication when or if the infection had resolved. Review of 9/2024, surveillance log identified R9 had a UTI infection. R9 was admitted August 2024. R9's face sheet had diagnoses of functional urinary incontinence, retention of urine and chronic kidney disease. R9's 11/01/24, significant (MDS) identified he had an indwelling catheter. R9 was prescribed an antibiotic cefdinir 300mg on 9/24/24. The surveillance log lacked indication when or if the infection had resolved. Review of 10/2024, surveillance log identified R25 had a UTI infection. R25 was admitted July 2024. R25's face sheet had a diagnosis of joint replacement surgery, right artificial knee joint, and pruritis. R25 was prescribed an antibiotic macrobid on 10/28/24. The surveillance log lacked indication of the antibiotic dosages, as well as, when or if the infection had resolved. Review of 11/2024, surveillance log identified use of antibiotics for residents who had a UTI, however, the surveillance log lacked indication of what the infection were, did not identify if a time out had been completed, and did not indicate when or if the infection had resolved. During interview on 11/20/24 at 2:19 p.m., with			F 881	The facility will conduct monthly audits of all residents on antibiotics for the next 3 months to verify compliance with appropriate antibiotic use protocols. Findings will be reported and reviewed at the monthly QA meetings Colonial Manor will be in compliance by 1/10/2025		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 881	Continued From page 36 registered nurse (RN)-A hired June 2024, and had not started her Infection preventionist (IP) training and was recently assigned to the duty as the facility's IP in September. RN-A stated the director of nursing (DON), who no longer worked at the facility, had a process in place for identifying antibiotic use for residents and would need to collaborate with the current facility administration to enforce consistency with the antibiotic stewardship program of tracking and logging all antibiotics. During interview on 11/20/24 at 3:27 p.m., with administrator would expect the nursing team to identify, track and maintain monthly log updates of all residents who had received antibiotics. Review of April 2023, Antibiotic Stewardship Policy identified the facility licensed nurses would follow up on pending cultures within 48 hours and would contact lab services at 72 hours to verify culture results, as well as antibiotics used to treat infections or to prevent unnecessary antibiotic use. Review of April 2023, Infection Control-Antibiotic Stewardship Program policy identified the facility would promote appropriate use of antibiotics to treat infections and reduce adverse effects related to antibiotic use under evidence based practice guidelines aligned with Centers for Disease Control and Prevention (CDC).Secondly, the facility would monitor antibiotic usage patterns on a regular basis, review the antibiotic stewardship policy annually, would evaluate clinical signs and symptoms of residents who was suspected of having an infection and would use antibiotic time out forms to assess the ongoing need for antibiotics. Lastly, the IP would oversee	F 881			

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F 881	Continued From page 37	F 881			
F 882 SS=F	Infection preventionist and would provide monthly reports, as indicated. Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 25 residents residing in the facility. Findings include: On interview on 11/19/24 at 10:29 a.m., the director of nursing (DON), indicated she started her employment at the facility in July 2024 and started doing the infection control role in October.	F 882			1/15/25
			The acting infection preventionist (IP) was immediately enrolled in the CDC infection prevention and control training program approved by CMS. This alleged deficient practice has the potential to impact all residents. A review of the past 6 months will be conducted to ensure no lapse in infection prevention protocols. Individuals assigned as the infection preventionist will be required to complete		

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F 882	Continued From page 38 The DON indicated she is enrolled in the Centers for Disease Control (CDC) infection preventionist course but has only completed one module so far and isn't very far into the training course. The DON added the role was going to be split between her and RN-A, also identified as Minimum Data Set (MDS) coordinator. On interview 11/19/24 at 10:23 a.m., RN-A indicated she is new to the infection preventionist role and has had no training at this time. RN-A stated she started at the facility at the end of June 2024 and was told to focus on MDS training first. RN-A indicated she is enrolled in a Boot Camp for Infection Control class the first week in December and is enrolled in the CDC infection preventionist course, but hasn't started it yet. On interview 11/19/24 at 10:59 a.m., the administrator stated she is aware the facility currently has no trained infection preventionist, but both the DON and the MDS coordinator are enrolled in the CDC course. Facility Infection Prevention and Control Program, dated 12/2022, included the early detection, prevention and management of infections are accomplished through effective oversight of the Infection Prevention and Control program that must include at a minimum, the following elements: To recognize and manage infections at the time of the resident's admission to the facility and throughout the stay; to follow recognized infection prevention and control practice while providing care that includes transmission based precautions and isolation; to provide program oversight including planning, organizing, implementing, operating, and monitoring; to maintain all of the elements of the program and	F 882	infection prevention and control training during first 90 days of employment. Review of the infection preventionist job description will be reviewed and updated as necessary. Job description was updated to reflect required course for future employees hired into this role. The Administrator and/or DON will review the infection preventionist's training as soon as it is completed. Findings will be reported to QA committee for review. The facility will request for ICAR to complete a site visit. Colonial Manor will be in compliance by 1/15/2024		

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F 882	Continued From page 39 ensuring the facility's interdisciplinary teams is involved in infection prevention and control practices; to develop and revise policies, procedures, and practices that promote consistent adherence to evidence-based infection control practices; to plan organize, implement, operate and maintain all the program elements; to define roles and responsibilities during routine implementation of practice and during unusual occurrences or times of potential risk of spread of infection or outbreak; to define and manage resident and employee health initiatives. The infection Prevention and Control Program components include the establishment of surveillance standards and frequency...; the development of the education component including the training in infection prevention and control practices that ensures compliance with facility requirements as well as State and Federal regulations.	F 882			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883			1/10/25

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F 883	Continued From page 40 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883			

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F 883	Continued From page 41 Based on interview and document review the facility failed to have records of the pneumococcal vaccinations for 1 of 1 resident (R19) and the influenza vaccine for 2 of 3 residents (R19, and R7) reviewed for immunization protocol for who had a signed agreement to receive the influenza vaccine. In addition, the facility failed to document for 1 of 1 resident (R19), the influenza vaccine had been offered and education on risks/benefits was completed. Findings include: R19's medical record identified R19 had been admitted to the facility on 1/18/24. R19's medical record lacked documentation of receiving any pneumococcal or influenza vaccines. R19's medical record lacked documentation of education on risks/benefits or declination of vaccines. Upon request of R19's record of vaccinations or refusal along with education completed, registered nurse (RN)-A confirmed 11/19/24 at 10:23 a.m., R19's record lacked documentation of any vaccinations and stated she would look further into it. Upon second request for vaccinations 11/20/24 at 8:01 a.m., nothing further was received. R7's medical record identified R7 had not received influenza vaccine. A consent form was present in the medical record that included consent on 11/4/24, for Covid and influenza vaccine. Covid vaccine was administered 11/7/24 but R7's record lacked documentation of receiving influenza vaccine.			F 883	The facility obtained documentation of pneumococcal and influenza vaccinations for the affected residents and ensured the influenza vaccine was offered and education on risks and benefits was completed for the resident in question. This documentation was promptly added to the residents' medical records. Verified vaccination records for R19 and R7. Administered influenza vaccines to R19(12/18) and R7(12/6) - still medically appropriate and consent was previously obtained. Audited residents' chart for previous pneumococcal vaccine dates to determine eligible of vaccines, will fax provider for order. Work with pharmacy to coordinate vaccination. Updated R19's chart with documentation of the influenza vaccine and MIIIC record. Confirmed no other residents were impacted by delays in vaccination or documentation errors. Monitored residents for any signs of vaccine-preventable illnesses and followed up promptly if concerns arose This alleged deficient practice has the potential to impact all residents. A comprehensive audit of all residents' immunization records will be conducted to identify and address any missing or incomplete documentation. Facility coordinated with pharmacy to provide consented vaccinations Staff responsible for immunization tracking and administration will receive education on proper documentation of		

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F 883	Continued From page 42 R26's medical record lacked documentation the influenza vaccine had been offered, education/risks discussed or documentation of refusal. On interview, 11/20/24 8:01 a.m., RN-A indicated influenza vaccine shots have not been given at the facility yet this year. RN-A indicated the consents for vaccinations were sent to the families late and they haven't received them all back yet. RN-A had not completed follow-up with the families who had not returned the consent forms. RN-A stated the influenza vaccine had been at the facility for a few months but none had been given at this time. Facility Resident Vaccinations policy dated 6/2023, included all residents are provided with the opportunity and are encouraged to receive pneumonia and COVID-19 vaccinations. Vaccinations will be offered to all residents per Center for Disease Control (CDC) recommendations. The RN Case Manager and infection control coordinator will be responsible for researching resident medical record and history to determine if the vaccinations have been given. Facility Infection Control - Resident Vaccinations policy dated 4/2023, included to minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal pneumonia by assessing that each resident is informed about he benefits and risks of immunizations and has the opportunity to receive, unless medically contraindicated, resident refused or already immunized, for the influenza and pneumococcal pneumonia vaccine. Beginning in the fall of each year, residents will	F 883	vaccination status, offering vaccines, and providing education on risks and benefits. The facility will reinforce adherence to the existing immunization protocol during staff meetings and ongoing training. The facility will conduct monthly audits of newly admitted residents immunization records for the next 3 months to verify proper documentation of vaccinations and education. Audit results will be reviewed by the QA committee to ensure continued compliance. Colonial Manor will be in compliance by 1/10/2025		

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F 883	Continued From page 43 receive an educational handout on the inactivated influenza vaccine which is to include benefits and risks and possible side effects. Staff will receive consent from resident or responsible party. Staff then administer, per standard of nursing practice and document vaccine on resident's vaccination record. If vaccine not provided, staff will document as to why the vaccine was not provided, such as medical contraindications, refusal, or vaccine already given prior to admission. Influenza vaccine is offered October to March of each year. Pneumococcal is offered year around.	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/19/2024. At the time of this survey, Colonial Manor Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION			K 000			

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

Electronically Signed

TITLE

(X6) DATE

12/22/2024

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.

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Colonial Manor Nursing Home was constructed as follows: **The original building was constructed in 1969, is one-story in height, has a partial basement 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 and was determined to be of Type II(111) construction;			K 000			

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K 321	Continued From page 4 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.6.3.1, 8.4.3.2, and 8.4.4.1. These deficient findings could have a wide impact on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that the following items were found: 1. Basement - Storage room has open penetrations, 2. 1st floor - Northwest wing storage room has open penetrations, 3. 1st floor - Activity storage room over 50 sq. ft. door would not automatically shut and latch, NOTE: Check the entire facility for these deficiencies. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 321	On December 20, 2024 The ESD closed the basement and first floor storage room with Fire rated caulking. For the 1st Floor activity room storage door, ESD has ordered new hingers, pending hinges come timely anticipated completion of this shall be by Jan 10, 2025.		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by	K 351		11/21/24	

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K 351	Continued From page 5 construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, section 9.1.1.7. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that there were newly installed insulated PEX piping that was zip tided to the sprinkler pipe in the basement medical records storage room. An interview with the Maintenance Director and Administrator verified this deficient finding at the			K 351	On 11/21/2024 ESD removed the pex piping from sprinkler pipe in basement. On 11/21 the ESD conducted a walkthrough of the building to assure that all other sprinkler piping was free from any attachment. Date of Compliance 11/21/2024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 6	K 351			
K 372 SS=F	time of discovery. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an wide impact on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that there were open pentarations through the following smoke barriers: 1. Northwest wing, 2. West wing An interview with the Maintenance Director and Administrator verified these deficient findings at the	K 372	On 12/4/2024 Colonial Manor's electric vendor installed smoke barrier precautions on Northwest Wing and West wing. Date of Compliance 12/4/204	12/4/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 372	Continued From page 7	K 372			
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.2, 19.7.1.4, 19.7.1.6, and 19.7.1.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that there was no documentation stating the fire drill for 4th quarter, 2nd shift was completed in 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	On 12/19/2024 ESD was reeducated on Fire Drill Process. Regional Director will audit drill for 3 months and share results with QA committee for review of need for ongoing monitoring.	12/19/24	
K 914 SS=F	Electrical Systems - Maintenance and Testing	K 914		1/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150			
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K 914	Continued From page 8 CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that the facility was unable to			K 914	ESD was educated on testing all receptacles in resident rooms on 12/19/2024 The ESD has updated the outlet identifiers to assure for all outlets being tested and match the documentation form. All resident room receptacle will be tested by Jan 10, 2025. Colonial Manor will be in compliance by Jan 10, 2025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 914	Continued From page 9 provide documentation showing that the facility has properly tested all electrical receptacles in the resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 914			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/19/2024. At the time of this survey, Colonial Manor Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:			K 000			

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

Electronically Signed

TITLE

(X6) DATE
12/22/2024

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: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
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K 000	Continued From page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Colonial Manor Nursing Home 2022 addition was constructed as follows: **The New Addition was constructed in 2022, is one-story in height, has no basement and was determined to be of Type II (111) construction. The 2022 addition is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 24 at the time of the survey.	K 000			
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW	K 372		12/4/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
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K 372	Continued From page 2 Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.1, 18.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a wide impact on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that there were open penetrations through the smoke barrier wall in south wing. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 372	On 12/4/2024 Colonial Manor's electrical vendor installed smoke barrier precautions in South Wing Date of Compliance 12/4/204		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		12/19/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
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K 712	Continued From page 3 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 18.7.1.2, 18.7.1.4, 18.7.1.6, and 18.7.1.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that there was no documentation stating the fire drill for 4th quarter, 2nd shift was completed in 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	On 12/19/2024 ESD was reeducated on Fire Drill Process. Regional Director will audit drill for 3 months and share results with QA committee for review of need for ongoing monitoring.		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914			1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COLONIAL MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
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K 914	Continued From page 4 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 11/19/2024 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that the facility has properly tested all electrical receptacles in the resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	ESD was educated on testing all receptacles in resident rooms on 12/19/2024 The ESD has updated the outlet identifiers to assure for all outlets being tested and match the documentation form. All resident room receptacle will be tested by Jan 10, 2025. Colonial Manor will be in compliance by Jan 10, 2025		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2024

Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, MN 56150

Re: State Nursing Home Licensing Orders
Event ID: E7X011

Dear Administrator:

The above facility was surveyed on November 18, 2024 through November 21, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

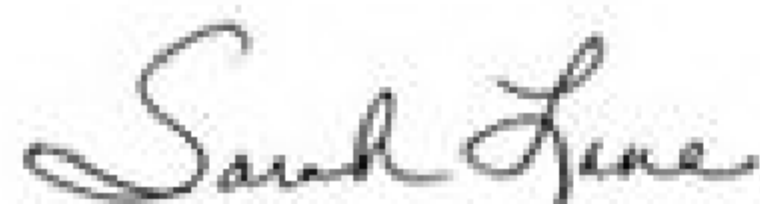
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/18/24, to 11/21/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

12/23/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2024
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: NO licensing orders were issued. H55721374C (MN102179) H55721375C (MN107795) H55721394C (MN108343) H55721500C (MN108338) H55721371C (MN108283) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000			

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete required quarterly Minimum Data Set (MDS) assessment at least every 92 days for 2 of 2 residents (R22, R24) reviewed for late quarterly MDS. In addition, the facility failed to ensure a residents hospice status was accurately coded on the MDS assessment for 1 of 1 residents (R15) reviewed for hospice and end of life. Findings include: "Quarterly assessments" is an OBRA '87-required, non-comprehensive assessment that must be completed at least every 92 days	2 550	Corrected	1/10/25	

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2 550	Continued From page 3 following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. R22's quarterly MDS assessment dated 7/16/24, identified R22 had moderately impaired cognition and had diagnoses which included stroke, high blood pressure, peripheral vascular disease (narrowed arteries reduces blood flow to arms or legs) and depression. R22 required substantial to maximum assistance with activities of daily living. Review of R22's record lacked documentation of a quarterly MDS completed after the quarterly review dated 7/16/24. R23's quarterly MDS assessment dated 7/15/24, identified R23 had severely impaired cognition and had diagnoses including stroke, high blood pressure, peripheral vascular disease and depression. Review of R23's record lacked documentation of a quarterly MDS completed after the quarterly review dated 7/15/24. On interview 11/19/24 at 10:14 a.m., registered nurse (RN)-A, also identified as MDS coordinator, reviewed R22 and R23's medical records. RN-A indicated R22's Medicare Part A was discontinued on 8/31/24 and R24 went off Medicare Part A on 8/31/24. RN-A stated when reviewing when the next quarterly assessment was due, used the Medicare Part A discontinuation dates. RN-A indicated she caught her error in November and plans to submit both quarterly assessments today.	2 550			

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2 550	Continued From page 4 On interview 11/19/24 at 11:02 a.m., the administrator indicated she was not aware the MDS quarterly assessments were late, but they should have been completed by the required dates. Facility policy on Comprehensive Assessments was received, but did not include information regarding quarterly assessments and timing. Accurate MDS R15's facesheet printed on 11/20/24, included diagnoses of protein-calorie malnutrition and encounter for palliative care. R15's current, quarterly MDS assessment dated 10/15/24, indicated R15 had moderately impaired cognition, had clear speech, could understand, and be understood. Hospice was not marked on the MDS. R15's significant change MDS assessment dated 7/5/24, indicated R15 was receiving hospice care. A progress note dated 7/3/24, indicated the provider faxed an order requesting hospice admission. During a telephone interview on 11/20/24 at 9:29 a.m., hospice agency administrative assistant (AD)-F stated R15 was enrolled in hospice on 7/8/24. R15's certification of terminal illness (CTI) diagnosis was protein calorie malnutrition. During an interview on 11/20/24 at 9:54 a.m., registered nurse (RN)-A who was also the MDS nurse, looked in R15's electronic medical record (EMR) and acknowledged hospice was not marked in Section O which indicated special treatments, procedures, and programs, for the	2 550			

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2 550	Continued From page 5 quarterly MDS assessment dated 10/15/24. RN-A immediately made a modification to add hospice to R15's MDS and stated she inadvertently missed that. Facility policy for accuracy of MDS assessments was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, or RAI coordinator could review the RAI manual, review policies and procedures to ensure timely and accurate completion of the MDS. The DON, designee or RAI coordinator could then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to document a complete recapitulation of stay for 1 of 1 resident (R28) reviewed for discharge. Findings include:	2 685	Corrected	1/10/25	

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2 685	Continued From page 6 R28's facesheet printed 11/20/24, identified an admission date to facility of 7/8/24 with diagnoses including: pressure ulcer of left foot (bedsore injury to the skin and tissue below the skin), depression, osteomyelitis (infection in bone) and paraplegia (paralysis that mostly affects the movement of the lower body). R28's discharge orders were dated 10/24/24, and signed by the provider. A progress note dated 10/25/24 at 9:51 a.m., by registered nurse (RN)-B included resident discharged to home with wife. Personal belongings, over the counter medication were taken home. Discharge orders reviewed with wife and resident and they state understanding. The medical record lacked a discharge summary. On interview 11/20/24 at 4:43 p.m., registered nurse (RN)-H, also identified as regional director of skilled care, confirmed she was not able to locate a discharge summary in the medical record and added there has been a turn over in staff so was unsure if it was completed but it should have been. On interview 11/20/24 at 4:47 p.m., RN-A, also identified as MDS coordinator, stated in the past social services was responsible for the discharge process and this was her first time doing a discharge. RN-A stated she was not aware she needed to fill out a discharge summary so this was not done but did send the orders with the resident upon discharge. Facility Death/Discharge Record Completion policy dated 8/23/24, included: On permanent discharge, nursing will complete discharge	2 685			

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2 685	Continued From page 7 summary to the extent possible in the electronic health record (EHR). On permanent discharge, nursing will secure the signature and address of the responsible person to whom released, the signature and address of the resident. The signature and address is recorded on the admission and discharge record. The nurse will complete the discharge summary in the EHR. The physician will be notified via fax, phone call or in person of discharge. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), administrator or designee could review applicable policies and procedures to ensure the timely completion of a resident's discharge summary; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 685			
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to document and monitor	2 965	Corrected	1/10/25	

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2 965	Continued From page 8 weight loss for 1 of 1 resident (R24) who had weight loss. In addition, the facility failed to obtain accurate weights for 2 of 2 residents (R24, R4) who were evaluated for nutrition. Findings include: R24's facesheet printed on 11/20/24, included diagnoses of stroke affecting left side, Parkinsonism (movement related disorder), dementia, mild with anxiety, hypoglycemia (low blood sugar), hyponatremia (low sodium level), and dysphagia (difficulty swallowing). R24's quarterly Minimum Data Set (MDS) assessment dated 7/15/24, indicated R24 had severe cognitive impairment, required setup help for eating and was dependent for transfers, mobility in wheelchair, dressing, and personal cares of activities of daily living (ADL's). No weight loss or gain. R24's care plan dated 10/23/24, indicated R24 was at risk for nutritional compromise related to right sided stroke and Parkinson's disease. Goals included resident will have adequate intakes of food and fluids with meals/snacks and resident will not have triggered weight loss of 5% in 30 days or 10% in 180 days. Interventions included allow resident to make meal choices, offer extra fluids between meals for hydration at activities and in common areas and room, resident will maintain ability to feed self, monitor monthly weights for any significant trigger, weigh and notify provider of weight changes per facility protocol. Additional interventions included monitor and record intakes of food and fluids, observe for any problems with chewing or swallowing and work with speech therapy for safest level of chewing and/or swallowing.	2 965			

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2 965	Continued From page 9 R24's physician orders dated 7/18/24, indicated R24's diet included regular with cut up meats at meals, thin liquids. A nurse progress note dated 11/13/24 at 1:25 p.m., by licensed practical nurse (LPN)-B included provider here for house rounds and orders for speech therapy to evaluate for increased complaints of swallowing issues. A nurse progress note dated 11/18/24 at 6:49 p.m., by LPN-A included R24 has had a diet change: Soft and bite size recommended and take a sip of water after each bite to ensure food is fully chewed and swallowed. Crush all pills, and thin liquids as ordered by speech therapy. R24 weights in pounds recorded since admission on 5/10/24 included: 5/11/24 - 146.2 6/13/24 - 147.4 7/11/24 - 151.4 7/29/24 - 184.8 8/5/24 - 141.0 9/5/24 - 184.8 9/5/24 - 194 9/27/24 - 142.2 10/14/24 - 140.2 11/4/24 - 135.2 11/11/24 - 123 11/14/24 - 121 - 17.24% change from admission 6 months prior. 10.5 percent change from 11/4/24. On interview 11/18/24 at 4:54 p.m., family member (FM)-A stated R24 has not had an appetite lately and will take bites and spit it out. FM-A indicated she was not aware of a weight loss but FM-B had informed her she isn't eating	2 965			

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2 965	Continued From page 10 much if at all. During observation on 11/18/24 at 6:30 p.m., R24 was eating in her room with husband present. Ate 50% of her meal. During observation on 11/19/24 at 12:45 p.m., R24 refused her lunch. Review of meals documented from 10/20/24 to 11/19/24 included: None: 11 times 0-25%: 7 times 26-50%: 11 times 51-75%: 12 times 76-100%: 24 times A nutritional assessment dated 11/12/24, observation and completion date by registered dietician (RD)-I, included a score of 10 indicating R24 is at risk of malnutrition. Notes included: R24 has had variations to weights and it appears some are inaccurate. She was readmitted with stroke and history of Parkinson's Disease. Admission height taken from hospital records 65" and weight 146 pounds. Ideal body weight is 125 pounds. Estimated nutritional needs 1300-1500 calories, 60-70 grams protein and 1600 ml fluids. Review weight 135 pounds which is a decrease of 3.5% in 30 days and a decrease of 7.5% in 180 days. Both do not trigger for weight loss. Diet is regular, regular texture (cut up) and regular liquids. Intakes are generally adequate with small portions preferred. Her husband comes to feed her meals which are consumed in room for most part. Her husband brings her a donut for mid - morning snack. She has her own teeth and there are no problems with chewing or swallowing at present. Nursing notes that she had difficulty swallowing on 10/4/24, however this was also	2 965			

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2 965	Continued From page 11 associated with anxiety and difficulty breathing. No other notes regarding problems. Medications pertinent to nutrition include laxatives with many medications recently discontinued. Mini Nutritional Assessment score: 9 - at nutrition risk NUTRITION DIAGNOSIS Inability to manage self care and physical inactivity related to stroke and Parkinson's disease as evidenced by requiring assistance with ADL's and structured meals to maintain nutrition status. NUTRITION INTERVENTIONS: Diet: regular, regular texture and regular liquids Cut up meat for ease of self feeding NUTRITION PLANS: Provide diet as ordered Snacks per facility protocol and resident preferences Monitor any difficulty with swallowing Monitor need for nutrition supplement if weights are accurately declining. Monitor intakes of food/fluids to ensure nutrition needs are being met. On interview 11/20/24 at 3:06 p.m., the registered dietician (RD)-I stated she has had issues with getting accurate weights or reweighs completed when requested. RD-I stated when she completed her recent nutritional assessment it was for the look back period dating from previous quarterly assessment 7/15/24 through 11/7/24. RD-I indicated if the weights for 11/12 and 11/14 were accurate, she should have been notified of the significant weight loss. RD-I indicated it has been difficult to complete accurate assessments when weights are sometimes inaccurate. RD-I stated she has requested re-weights but they are never completed. RD-I indicated she writes possible inaccuracy of weights in her reports	2 965			

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2 965	Continued From page 12 which go to all the department heads, so they are aware of the request for re-weights and possible inaccuracy of weights. On interview 11/20/24 at 3:16 p.m., licensed practical nurse (LPN)-A reviewed R24's weights and stated there are obvious operator errors present and R24 should have been reweighed with the inaccurate weights that struck out as errors. LPN-A added he has requested a lot of reweighs at the facility due to "crazy" weight difference since he has been at the facility at the end of September. LPN-A stated the most recent weight from 135 to 123 pounds in one week would require notification to the physician. LPN-A added R24 hasn't been eating much so the weights could be accurate. LPN-A reviewed the record and confirmed there is no documentation present of physician notification of the significant weight change. On interview 11/20/24 at 3:25 p.m. interim case manager (ICM)-K confirmed a 12 pound weight loss in one week is a significant weight loss and the physician should have been notified. ICM-K indicated weights that are obviously not accurate need to be reweighed and inaccurate weights struck out as error. On interview 11/20/24 at 3:29 p.m., nurse consultant (NC)-L confirmed the facility has had issues with the monitoring and accuracy of weights and it is on a list to address. On interview 11/20/24 at 3:32 p.m., the dietary manager (DM)-J indicated she has met with R24 and FM-B regarding her intake and snacks. DM-J indicated she has observed FM-B eating portions of R24's food so is not sure how accurate the intake documentation is. DM-J	2 965			

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2 965	Continued From page 13 confirmed she has had difficulty getting accurate weights with some weights being obvious significant errors. When reweighs are requested, they don't happen. DM-J confirmed she, the RD and the physician should have been notified of R24's recent significant weight loss. R4's facesheet printed on 11/20/24, included diagnoses of severe protein-calorie malnutrition and dysphagia (difficulty swallowing). R4's quarterly Minimum Data Set (MDS) dated 9/6/24, indicated R4 was cognitively intact and was dependent upon staff for activities of daily living (ADL's). R4's orders did not specify obtaining measured weights. R4's care plan with revised date of 10/2/24, indicated R4 was at nutrition risk due to history of poor intake and history of requiring a feeding tube. In addition, staff were to monitor monthly weights for significant changes, notify the provider of weight changes per policy, and to weigh R4 per facility protocol or provider orders. Review of R4's weights showed weights consistently over 100 pounds from 8/16/24, to 10/16/24, except for an aberrant weight on 9/30/24, of 82.6 pounds. Review of dietician progress notes indicated: --10/1/24: Weight listed in the EMR (electronic medical record) on 9/30/24, is 82.6 # (pounds). Question the accuracy of this. --10/15/24: Weights appear inaccurate with weight on 9/16/24, 107# and weight on 9/30/24, of 82.6 #.	2 965			

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2 965	Continued From page 14 During a telephone interview on 11/19/24 at 9:52 a.m., registered dietician (RD)-I stated she suspected some inaccurate resident weights but had not spoken to the nursing staff or director of nursing (DON) about it. RD-I stated she included this information in her nutrition reports which went to department leaders, so they were aware of the possible inaccuracies of weights. During an interview on 11/19/24, at 11:20 a.m., the DON stated she was aware of inaccuracies of weights; that it has been identified one or two months ago. The DON stated because of this, staff re-weighed resident wheelchairs and updated the wheelchair weight book. The DON stated she had then asked nurses to obtain residents weights rather than nursing assistants (NA's). The DON stated she would look for the written communication to the nurses regarding this change, but she used mostly verbal communication to inform them. During an interview on 11/19/24 at 12:27 p.m., licensed practical nurse (LPN)-B stated had not received communication from the DON indicating only nurses should be weighing residents. LPN-B stated she was aware of weight inaccuracies, adding a physician, "Got after me about that one day." LPN-B stated each day she wrote in a small notebook which residents needed a measured weight. After a NA obtained the weight, the NA recorded it in the notebook, then LPN-B calculated the weight without the wheelchair and entered it into the EMR. While she had not seen evidence of it, LPN-B stated she wondered if NA's were weighing residents in a wheelchair with the oxygen tank attached, adding that could account for the weight fluctuations. During an interview on 11/20/24 at 8:56 a.m., the	2 965			

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2 965	Continued From page 15 administrator was aware of inaccurate weights being recorded in resident records. The administrator stated the inaccuracies were sometimes due to staff not waiting for the scale to be fully turned on and therefore the weight was skewed. The administrator stated the maintenance director had calibrated the scale and the DON provided education to the nursing staff. The administrator stated she would look for the documentation of the education and stated it did not indicate (as the DON had stated), that only nurses would weigh residents rather than NA's. During an interview on 11/21/24, at 8:41 a.m., in the shower room with the wheelchair scale, NA-H stated NA's weighed a residents in their wheelchair, then gave the charge nurse the weight. NA-H stated she thought the nurse deducted the wheelchair weight. Observed a sign on the scale indicating to remove the oxygen tank [before weighing the resident]. During an interview on 11/21/24 at 9:16 a.m., LPN-B stated she got sick of inaccurate weights one weekend, so created a list of the weight of resident wheelchairs so that nurses could use that information when calculating weights. LPN-B stated she shared the list with the nursing staff and made the DON aware too. During an interview on 11/21/24 at 9:19 a.m., nursing assistant (NA)-F stated residents were weighed in the shower room. If a resident had an oxygen tank on their wheelchair, that was removed. NA-F stated she gave the total weight measurement (resident and wheelchair) to the nurse who wrote it down, but NA-F didn't know what happened after that.	2 965			

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2 965	Continued From page 16 Facility Weighing and Weight Changes of Residents policy dated 4/22, included weekly weights are taken by nursing staff and entered into the electronic medical record. The DM or RN/LPN will review weights and request for reweighs if there is a change of plus or minus 3 pounds in a week. If reweigh confirms a weight change of 3 pounds gain or loss, daily weights will be requested by RN/LPN or DM for 7 days to observe resident's weight. The DM will evaluate for significant weight gains and losses. If significant weight charges are documented, the DM will report to the RD to review. If weight loss is confirmed and the resident's meal intakes are more than 50%, the DM will report to the RD and provider with confirmation of significant weight change. The DM will continue to observe resident's weight for another week before starting interventions, unless recommended to do otherwise by RD or provider. If weight loss is confirmed and the resident's meal intakes are less than 24-50%, the DM will report to the RD and provider with confirmed weight loss. The DM will start interventions as stated in the nutrition at risk policy and procedure. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for significant weight loss to assure they are receiving the necessary treatment/services to prevent further weight loss. The DON or designee, could conduct random audits of the delivery of care including weights and weight loss, to ensure appropriate care and services are implemented; to reduce the risk for significant weight loss. The DON, or designee could then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965			

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2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietician (RD), the dietary manager (DM) was certified to oversee nutrition and food services. This had potential to affect all 25 residents who resided in the facility. Findings include: During an interview on 11/18/24 at 12:25 p.m., dietary manager (DM)-J stated she had been employed at the facility since 12/18/23 and was not a certified dietary manager nor had she started any classes. DM-J stated she was notified today the administrator was going to get her signed up for the certification class. DM-J stated she does have a Food Safety Certificate, which she completed in 2019. During an interview on 11/20/24 at 10:45 a.m., the administrator was aware DM-D was not certified as a dietary manager. The administrator stated	2 980	Corrected	1/10/25	

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2 980	Continued From page 18 she understood the registered dietician coming once a week would be adequate until DM-J got her certification. The administrator stated, "DM-J has not been signed up for her dietary certification classes". Dietary manager job description undated, skills/qualifications included, knowledge of state and federal food regulations, Serv-Safe Certified, current certification as a Certified Dietary Manager (CDM) or dietician preferred or willing. If not licensed as CDM will encourage the candidate to get obtain their CDM certificate. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure the dietary manager had the proper qualifications for the position. The administrator or designee could provide guidance to the dietary manager in effort to achieve proper qualifications within a specified time frame. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1	21375	Corrected		1/10/25

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21375	Continued From page 19 resident (R26) who had a urinary ostomy Findings include: R26's facesheet printed on 11/20/24, included diagnoses of neuromuscular dysfunction of the bladder (when the nerves and muscles that control the bladder don't work properly), bladder-neck obstruction, and a urinary diversion device - a urinary ostomy (an opening in the abdominal wall to redirect the urine). R26's admission Minimum Data Set (MDS) assessment dated 11/4/24, indicated R26 had moderately impaired cognition, clear speech, could understand and be understood. R26, who didn't walk, required staff assistance for most activities of daily living (ADL's), including toileting. R26's physician order dated 11/5/24, indicated to change two-piece urostomy pouch on Tuesday and Friday if leaking. During an observation on 11/19/24 at 1:20 p.m., observed an EBP sign hanging on R26's door which indicated staff were to don personal protective equipment (PPE) including gown, gloves, and mask, prior to providing care. Nursing assistant (NA)-F was observed taking a sit-to-stand mechanical lift into R26's room without donning PPE. NA-F assisted R26 from wheelchair to mechanical lift to toilet without PPE, then exited the room. During an observation and interview on 11/19/24 at 1:40 p.m., NA-F donned PPE - gown, gloves, and mask - to enter R26's room. NA-F stated she didn't don PPE to take R26 into the bathroom and assist him onto the toilet because she didn't touch him during that process.	21375			

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21375	Continued From page 20 During an interview on 11/19/24 at 1:54 p.m., along with NA-F reviewed the EBP sign on the outside of R26's door. NA-F admitted she didn't wear PPE when toileting R26 with the sit-to-stand mechanical lift, adding, "It's a fine line -- I can put the sling [for the lift] on him without touching him." During an interview on 11/19/24 at 1:58 p.m., the director of nursing (DON) stated whether or not staff donned PPE to care for a resident in EBP depended on the "distance." When asked if there was a distance requirement, the DON stated would need to look at the policy. During an interview on 11/19/24 at 2:03 p.m., the DON provided the EBP policy and stated according to the policy, staff should wear PPE when toileting a resident in EBP. During an interview on 11/19/24 at 4:22 p.m., registered nurse (RN)-A, who was also the infection preventionist, stated nursing staff had a meeting on 11/11/24, where EBP was reviewed. A copy of sign-in sheet was provided and NA-F's signature was listed. Facility Enhanced Barrier Precautions policy with revised date of 6/21/24, indicated EBP was used with residents who had indwelling medical devices; that an indwelling medical device provided a pathway for pathogens in the environment to enter the body and cause infection. EBP was used when performing high contact resident care activities such as toileting. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to a comprehensive infection control	21375			

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21426	Continued From page 22 by: Based on interview and document review, the facility failed to complete tuberculosis (TB) symptom screening and tuberculin skin test (TST) for 2 of 5 residents (R24 and R26) reviewed for TB. In addition, the facility failed to ensure 3 of 5 staff (NA-E, DON, DA-A) was appropriately given a TB symptom screen and TST test upon hire Findings include: R24 was admitted May 2024. R24's vaccination records identified a TST on 5/10/24 and lacked a complete first step TST reading and result of the TST. In addition, a second TST test was started on 5/20/24 and was read on 5/22/24. R26 was admitted October 2024. R26's vaccination records lacked a completed TB symptom screening and no initial TST. Review of December 2022, Infection Control-TB Screening for Residents of Nontraditional Facility-Based Setting policy identified the facility will conduct TB screening and testing according to Centers of Disease Control (CDC) guidelines. In addition, the facility would provide correct documentation of the Mantoux results and would include the measurements and documentation of positive or negative results. Employees Nursing assistant (NA)-E had a hire date of 5/06/24. NA had no baseline TB symptom screening upon hire. Director of nursing (DON) had a hire date of 7/23/34. RN had no baseline TB symptom screening upon hire. In addition, the facility failed	21426	Corrected		

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21426	Continued From page 23 to administer an initial TST. Dietary aide (DA)-A had a hire date of 9/27/24. The facility lacked documentation of an initial TST upon hire. During interview on 11/20/24 at 3:24 p.m., the administrator stated her expectations would be for residents upon admission to the facility and all healthcare employees to have an initial TB symptom screening and TST to determine their status and prevent the transmission of TB to others. During interview on 11/20/24 at 3:58 p.m., with DA-A had started her initial TST but was not read within 48 to 72 hours. She was informed by the director of nursing (DON) that she would need to restart her initial TST. She confirmed she had received a second TST for the initial screening and had been read by the DON, but was unsure if the paperwork had been completed. Review of 7/2023, Facility Assessment identified the facility would use infection prevention tools and outside organization resources to identify, screen, educate and utilize standard and transmission-based precautions for residents, employees, and visitors along with medical practitioners for continuity of care. Review of 11/28/23, Tuberculin Screening Protocol-Mantoux identified healthcare workers would receive a two-step TST skin test for all new employees. The first step would be given prior or start of employment and the second step would be given 7 to 21 days after the first step under the direction of the medical director. SUGGESTED METHOD OF CORRECTION: The	21426			

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21426	Continued From page 24 infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426			
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.	21880		1/10/25	

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21880	Continued From page 25 Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 resident (R19) who reported missing property. Findings include: R19's significant change Minimum Data Set (MDS) assessment dated 10/2/24, identified R19 had moderately impaired cognition.	21880	Corrected		

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21880	Continued From page 26 On interview 11/18/24 at 1:54 p.m., R19 stated he has had multiple packs of handkerchiefs lost when sent to laundry along with a couple shirts since his admission to the facility January 2024. R19 stated he is not sure how many handkerchiefs come in a pack but he has told multiple staff about his missing items. On interview 11/20/24 at 9:41 a.m., nursing assistant (NA)-A stated when residents inform them of missing belongings including clothing, would tell the charge nurse. NA-A was unsure what happens after that. On interview 11/20/24, at 9:45 a.m., NA-B stated staff fill out a missing belonging sheet and inform the charge nurse of the missing belongings. NA-B added they also put the form in the binder at the nurse's station. On interview 11/20/24 at 9:45 a.m., the nursing department coordinator (NDC)-A stated there was no book of missing belongings at the nurses station. NDC-A was able to locate a form to complete for missing or damaged items but thinks they are turned into social services to follow-up on and file. On interview 11/20/24 at 9:48 a.m., registered nurse (RN)-A, stated social services would have the missing belongings binder with the completed forms. RN-A indicated they currently do not have a social worker and she would look for them in her office. On interview 11/20/24 at 9:54 a.m., R19 stated "every time I get new hankies, they just disappear in laundry". R19 stated his wife just got him a new pack and he is already down to 1 or 2 of them. R19 also indicated he has told staff	21880			

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21880	Continued From page 27 multiple times about them missing along with his shirts. On interview 11/20/24 at 10:24 a.m., laundry (L)-D indicated she has been aware of R19's missing handkerchiefs for the last month or two but not of his shirts. L-D stated they have looked for the missing handkerchiefs but have not been able to locate them. L-D indicated social services follows up with the residents. On interview 11/20/24 at 4:08 p.m., the administrator stated social services does keep a binder of missing belongings forms, but there was no form for R19's missing shirts or handkerchiefs present. The administrator confirmed a missing belongings form should have been completed and the grievance process was not followed through. The administrator stated "any missing belonging is a big thing". Facility Missing or Damaged Items policy dated 2/19, included: - Person told of missing item to gather as much information as possible and initiate search for item. - If item is not found, complete the Missing or Damaged Item report form, and report it to charge nurse. - Charge nurse to determine further action in attempts to locate missing item and notify other departments as necessary. - Original copy of missing or damaged item report to be given to Social Services. - Social Services maintains file of all pertinent information regarding missing or damaged items. SUGGESTED METHOD OF CORRECTION: The director of social services or administrator could educate all appropriate staff members on the	21880			

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21880	Continued From page 28 process of reporting missing personal items. The director of social services or administrator could develop monitoring systems to ensure ongoing compliance and follow up on missing items is being done. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880			