Electronically delivered
August 15, 2022

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

RE: CCN: 245572
Cycle Start Date: July 28, 2022

Dear Administrator:

On July 28, 2022, 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, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 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 October 28, 2022 (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 January 28, 2023 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/25/22 - 7/28/22 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		9/9/22

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

Electronically Signed | 08/24/2022

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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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview the facility failed to maintain, test and inspect the on-site emergency generator system per NFPA 99 (2012	E 041	It is the practice of Colonial Manor to assure generator testing is completed for proper functioning. No residents were directly impacted by the deficient practice	

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E 041	Continued From page 3 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 5.6.4.5.1*, 8.4.9, 8.3.4. This has the potential to affect all 40 residents residing in the facility, staff, and visitors. Findings Include: See K0918 During a facility tour between 10:30 a.m. and 1:30 p.m. on 7/27/22, observations, staff interview, and documentation reviewed revealed the following: Findings include: 1. During observation the generator battery was installed greater than 3 years ago. 2. During documentation review, no records were available for review to confirm that last 36 month, 4 hour run and load-bank test. The maintenance director confirmed the above findings at the time of discovery.	E 041	The facility recognizes that all Residents, staff and visitors have the potential of being affected by the deficient practice Education was provided to Director of Maintenance the importance to have this on the calendar to assure the company has this test completed timely and is on their schedule. The Director of Maintenance has been in contact with vendor to schedule the annual inspection, complete the 4 hour run and load bank test and 3 year battery check. It is scheduled to be completed on 8/24/2022 To assure this does not occur in the future the Maintenance Director will place a notification on his calendar to use as a reminder to this preventative maintenance and has also placed a sticker in the operator panel of the generator identifying the date due of next 4 hour run and 3 year battery check. Director of Maintenance will submit a copy of the completed paperwork to Administrator to assure testing and battery inspection was completed. Administrator will add to calendar to assure it is completed timely at next due inspection	
F 000	INITIAL COMMENTS On 7/25/22, to 7/28/22, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements	F 000		

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F 000	Continued From page 4 of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		9/9/22

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F 583	Continued From page 5 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a resident's right to personal space privacy for 1 of 1 resident (R25), who voiced concern regarding resident (R7) coming into room on multiple occasions, touching personal belongings without permission. Findings include: R25's quarterly Minimum Data Set (MDS) assessment dated 7/1/22, indicated R25 had moderately impaired cognition and required extensive assistance of 1 staff for activities of daily living (ADL). The MDS also indicated R25 had diagnosis list including down syndrome (genetic developmental and intellectual disorder) and obesity. R7's quarterly MDS assessment dated 4/29/22, indicated R7 had severely impaired cognition. R7's care plan, printed on 7/28/22, indicated she required limited to extensive assist of 1 staff for ambulation. Furthermore, R7's care plan for	F 583	F583 It is the practice of Colonial Manor to assure each resident has the right to privacy. On 7-25-22 the DON interviewed resident (R25). It was offered and agreed upon by (R25) and roommate for a STOP sign to be placed across doorway. DON followed up with resident on 8-1-22, and resident reported that the STOP sign is effective. Privacy policy was reviewed for updates. All residents have the potential to be effected. Staff will be educated on intervention and instructed to inform the charge nurse or a member of the leadership team that if (R25) or other residents report an invasion of personal space and privacy that interventions shall be implemented	

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F 583	Continued From page 6 wandering included interventions consisting of; asking resident what they need or are looking for, conversing at resident's level, distraction with conversation or activity of interest to keep resident busy, ensuring needs are met and comfort level is facilitated, give simple directions, redirect as needed, taking resident for walk if weather permits, use of wanderguard system-check placement every shift and functionality daily and as needed. R7's face sheet, printed on 7/28/22, included diagnosis of; dementia with behavioral disturbance (a cognitive and behavioral disorder), anxiety (mood disorder), depression (mood disorder), insomnia (sleep disorder), restlessness and agitation, and irritability and anger. During an interview, on 7/25/22 at 5:50 p.m., R25 indicated was bothered by R7 always coming into room, tried to take personal items. R25 stated staff were aware of multiple incidents of R7 coming into room without permission, staff would come into room and escort R7 back to her room. When interviewed, on 7/27/22 at 9:09 a.m., nursing assistant (NA)-A indicated awareness of R7 going into R25's room, occurred 1-2 times in past couple of months, typically occurred during evening hours. NA-A stated when R7 went into R25's room, R7 would touch R25's personal belongings on nightstand and tray table, knew that bothered R25. NA-A indicated R7 would be escorted back to own room when staff noticed her in R25's room or R25 pressed call-light for staff assistance. NA-A stated was unaware of prevention interventions in place to keep R7 out of R25's room, staff provided re-direction when incidents occurred.	F 583	timely. Behavior monitoring for the past 30 days was reviewed (R7). DON or designee will review Behavior monitoring flowsheet and progress notes for episodes of privacy invasions daily x 1 week, and then weekly x 4 weeks. To assure the intervention in place is adequate for R25 DON or designee will follow-up with resident affected weekly for one month to assure intervention is working and document in residents medical record her findings. These findings will be reported the the QA committee. Residents right to privacy was reviewed with residents at resident council on 9/2/22, all residents in attendance expressed feeling their privacy is protected and expressed no concerns at this time.	

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F 583	Continued From page 7 During an interview, on 7/27/22 9:49 a.m., NA-B indicated R25 reported two incidents regarding R7 coming into R25's room without permission approximately 1-2 weeks ago, discussed during nursing report, aware incidents caused agitation for R25. NA-B stated staff removed R7 from R25's room, increased safety monitoring for R7. NA-B indicated should having something in care plan to prevent R7 going into R25's room, as invasion of R25's privacy. When interviewed, on 7/27/22 at 1:35 p.m., the director of nursing (DON) indicated awareness of R7 occasionally wandering into residents' rooms, stated was unaware R7 wandering into R25's room was a bother for R25. Furthermore, the DON indicated awareness of R7's personal care needs with wandering, expectation was for staff to redirect and provide R7 with an activity. The DON indicated if any concerns with residents wandering became an issue for other residents, staff should have notified her of concerns, updated resident's care plan with new interventions. The DON confirmed R7 wandering into R25's room as an invasion of personal space and privacy. Facility policy and procedure, titled "Privacy," revised 4/22; indicated it was the policy to provide privacy and dignity of all residents; procedure included personal privacy and stated residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		9/9/22

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F 585	Continued From page 8 §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 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	F 585		

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F 585	Continued From page 9 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 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,	F 585		

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	245572	A. BUILDING _____ B. WING _____	07/28/2022

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F 585	Continued From page 10 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 interview and document review, the facility failed to ensure grievances related to noise levels were acted upon for timely resolution for 1 of 1 resident (R13) reviewed with ongoing complaints of not being able to sleep at night because of a neighbors loud TV noise. Findings include: During interview on 7/25/22, at 4:40 p.m. R13 stated he has not been able to sleep at night because his next door neighbor (R11) always has his TV on loud during the night. R13 indicated he reported his concern to the staff several weeks ago, but it still continues. R13 indicated there were no staff that followed up with him if his concerns were resolved. R13 further indicated he reported to the nursing staff recently, R11 continues to have the TV on and on high volume. Review of the nursing progress note entry's indicated: -6/3/22, at 5:54 a.m. indicated R13 complained of R11's TV being to loud and asked staff to turn it	F 585	It is the practice of Colonial Manor that resident concerns and grievances are followed up on timely. (R11) has expired. On 8/23/2022 1:1 education was provided to the Grievance Official on the policy and the requirement to complete a grievance form and track in the log book a complaint that is not settled by an informal discussion. The grievance policy was reviewed with no changes needed at this time. Other residents who may have been impacted by this deficient practice will be interviewed by LSW on or before 9/9/22 to evaluate concerns regarding television noise. A grievance/concern form will be completed and be a working document until the concern is resolved, along with	

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F 585	Continued From page 11 down so that he could sleep. The note indicated a message was left for the facility social worker regarding R13's concerns. -6/13/22, at 5:26 a.m. indicated the staff noted R11's TV being very loud. The staff approached R11 and asked politely to turn it down. R11 became verbally upset and stated he was not being treated fairly and was upset. -6/14/22, at 3:03 a.m. indicated R13 complained of R11's TV being to loud and asked staff to turn it down. so that he could sleep. The note indicated a message was left for the facility social worker regarding R13's concerns. - 6/17/22, at 10:51 a.m. by the facility licensed social worker (LSW) indicated she met with R11 to discuss the TV volume related to other resident complaints. Discussed with R11 if he would be open to wearing headphones when watching TV. R11 stated he has a pair but does not know how to use. Staff will assist R11 with the headphones and until then R11 was asked to keep the volume on the TV on low. -6/18/22, at 3:45 a.m. indicated the staff could hear R11's TV from the nurses station. The staff went to ask R11 to turn his TV down. R11 became upset and started yelling stating I can watch my TV if I want. The staff told R11 he could watch his TV but needed to turn the volume down. The staff discussed with R11 he needed to close his door, turn his TV down or use his headphones, but he refused those options. R11 did eventually turn the TV down. On 726/22, at 2:00 p.m. facility grievances were requested for the past 3 months, but did not included a grievance related to R13's complaint of the loud TV Interview on 7/27/22, at 11:45 a.m. the	F 585	tracking this in the grievance log. All staff will be educated on the importance to report a concern to the person in charge and/or grievance official. A reminder to staff will be provided as to where they can find the grievance forms to complete if needed. The grievance policy, grievance resident right was reviewed with resident council on 9/2/22. At this time residents in attendance did not have concerns The grievance log will be reviewed at monthly QA to assure timely follow through and/or to continue to discuss resolution to an ongoing concern.	

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F 585	Continued From page 12 administrator indicated R13's concerns related to R11's TV being too loud had been discussed with R11. The administrator indicated a formal grievance report had not been completed and confirmed there had been no follow up with R13. The administrator indicated she had not been aware of the continued concerns R13 had with the TV and thought it had been resolved. The administrator indicated a grievance report should have been completed and a follow up with R13 per facility grievance policy guidelines. Facility policy Grievance revised on 1/22, indicated the facility grievance form shall be utilized to provide written documentation of any concern expressed by a resident or resident representative and to record the follow-up action taken and results thereof. Attach any additional information as needed to provide a complete and accurate investigation into the grievance. All staff will be educated regarding grievance procedures and resident's rights. Procedure: (1) Any resident, family member, or concerned persons with grievances should share this with the Grievance Official, Tricia Larson, LSW, Director of Social Services. (2) If not settled by informal discussion, a grievance should be written and given to the Administrator. (3) A grievance will then be shared with the Resident Care Review Committee, which is composed of the Administrator, Director of Social Services, and Director of Nursing. (4) A written response to the concerned person or persons will be made within 7 days.	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		9/9/22

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F 604	Continued From page 13 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R15) who utilized a self-release belt as a restraint.	F 604	F604 -It is the practice of Colonial Manor to assure that residents have the least restrictive safety devices utilized to promote the residents independent functioning while protecting their health and safety.	

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F 604	Continued From page 14 Findings include Observation on 7/26/22, at 9:24 a.m. R15 was noted to be sitting in a wheelchair with a seat belt attached to wheelchair, and clipped around her waist. When asking R15 if she could release the belt, she shook her head "no". During this time, R11 was sitting calmly in her wheelchair and made no attempts to stand or move in her chair. Observation on 7/26/22, at 3:15 p.m. R15 was noted to be sitting in her wheelchair with a self-release belt attached to her chair. The belt was clipped around her waist. Nursing assistant (NA)-F asked R15 to unclip the belt. R15 was unable to do this. NA-F indicated for at least the past 2 years, R15 was unable to unclip the self-release belt. NA-F further indicated R15 had made no attempt to transfer self or even move in her chair independently. R15's quarterly minimum data set (MDS) assessment dated 5/27/22, identified utilizing a restraint in the wheelchair as well as an alarm. The MDS identified R15 as requiring extensive assistance with mobility and activities of daily living (ADL's). R15's brief interview mental status (BIMS) was a "3" (severe cognitive impairment) R15's mechanical device assessment dated 5/26/22, identified R15 as having muscle weakness, arthritis and Alzheimer disease. R15's posture is good, but is unsteady and utilizes a mechanical aid and 2 staff assist for transfers. R15's fall risk analysis assessment dated 5/26/22, identified no falls in the past 3 months. R15 has a self releasing belt alarm in the wheelchair and uses a body pillow when in bed	F 604	R15's PCP and Medical Director were informed of restraint removal plan at QA committee meeting on 8-3-22. The facility's MDS Coordinator spoke with resident's family members regarding resident's right to be free from physical restraints. Family expressed understanding with hesitation and agreed to remove. R15's restraint was discontinued on 8-17-22. Restraint policy was reviewed for updates to include that if a resident and/or representative is requesting use of a restraint they will be informed of the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives of restraints No other residents have been effected, as no other restraints are in use. Restraint use will continue to be reviewed by the QA committee on a monthly basis.	

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F 604	Continued From page 15 for positioning. The assessment indicated the belt was utilized as a restraint, and had not been removed because R15's family requested the continued use R15's physical restraint assessment dated 5/26/22, identified R15 as utilizing a wheelchair self-release belt restraint, that she is unable to remove. Risks were reviewed with R15's family, but still requested the continued use of the restraint. Removal is discussed at each care conference. The restraint is released every 2 hours. R15 no longer attempts to transfer self or fall. R15's physician visit note dated 6/8/22, indicated R15 was observed sitting in a wheelchair with a restraint belt around her. The note indicated the family requested the restraint. The provider did not address the use of the restraint, other than the family requesting the use. R15's care plan dated 6/21/22, identifies R15 as having a seat belt restraint when in wheelchair, related to weakness, falls and poor decision making. This is per family request, despite several staff request to have it removed. Review of the medical record indicated R15's self-release belt was first initiated on 5/31/13. At that time, R15 was assessed to be able to self-release the belt. On 6/7/18, R15 was assessed to not be able to release the belt. At this time, the belt was considered a restraint as assessed. The assessment further indicated even though the belt was considered a restraint, R15 continued to utilize per family request. Interview on 7/26/22, at 3:25 p.m. facility MDS	F 604		

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F 604	Continued From page 16 coordinator confirmed the seat belt utilized by R15 was assessed as a restraint. The MDS coordinator indicated R15 had been unable to release the belt since 2018. The MDS coordinator indicated R15's belt restraint is discussed at each care conference with the residents family. The discussion includes the removal of the seat belt and review of the risks for continued use. R15's family has declined the removal. Interview on 7/27/22, at 10:30 a.m. NA-G indicated R15 has not attempted to transfer self for at least the past couple of years. NA-G further indicated she had been aware the seat belt on R15's wheelchair was a restraint, because she was unable to release the clip on the belt. Interview on 7/27/22, at 11:30 a.m. the administrator and DON confirmed R15 continued to utilize a self-release belt as a restraint since 2018, even though R15 is unable to release the belt. The administrator and DON further indicated there had been many discussions with R15's family, related to the risks of continued use of the restraint. R15's family continued to decline. The DON indicated R15 has had the self-releasing belt since 2013, because of continued self-transfer without assistance. R15 required assistance at that time due to weakness, but would not ask for help. This resulted in many falls. Facility policy Restraints revised on 4/22, indicates the policy is to promote and maintain the resident's independent physical functioning in medical situations which are life threatening. To protect the resident from injury and to ensure the physical safety of the resident or other residents. The policy procedures include:	F 604		

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F 604	Continued From page 17 1. Less restrictive safety devices will be tried before a restraint is applied. 2. When these measures fail, a positioning device/restraint may be applied to enable and promote greater functional independence. 3. The resident/resident representative or legal representative will be informed and must agree to its use. 4. The physician is contacted, and a specific order is obtained. The order must indicate the type, frequency, and duration of use. 5. Once a positioning device/restraint is identified as a mechanism to enable the resident to attain/maintain his/her highest level of physical, mental, psychosocial function, the Mobility/Restraints Assessment Evaluation and Care plan will be adjusted. 6. The care plan reflects that use of this device is periodically re-evaluated, at least quarterly, and efforts to discontinue its use are documented. 7. When a positioning device/restraint is deemed appropriate, the restraint will be released every two hours and the resident will be repositioned. 8. Always apply a positioning device/restraint correctly. 9. Documentation of the device use will be reflected in the resident's chart in the location of the care plan and restraint assessment kept under the Assessment tab. 10. Emergency use of waist restraint or wheelchair belt restraint may be used if a resident is in an immediate threat to health or safety of self and/or others. A physician and resident representative/guardian will be notified of the application of restraint and further orders will be received.	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		9/2/22

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F 684	Continued From page 18 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provision of ongoing treatment for edema for 1 of 2 residents (R9) reviewed for quality of care, who required elevation to treat edema. Findings include: R9's face sheet, printed on 7/27/22, included diagnosis of edema, atherosclerotic heart disease (disorder of heart affecting blood flow), peripheral vascular disease (PVD), a disorder of heart affecting blood flow), and hypertension (HTN). R9's quarterly Minimum Data Set (MDS) assessment, dated 4/29/22, indicated R9 had moderate impaired cognition, impairment of left upper and lower extremities; and required extensive assistance of 2 staff with bed mobility, transfers, dressing, toileting, and personal hygiene. R9's provider orders, printed on 7/27/22, included medications to treat edema,Lasix 30 mg daily and Thiamine 100 mg daily; treatments for edema consisting of; daily weights, and application of tubi-grip (compression bandage) to be applied in	F 684	F684 □ Is is the practice of Colonial Manor to assure treatment is provided as ordered for residents with edema. On 7/27/22 an order was placed on eMAR for nursing staff to document the elevating of R9's legs twice daily. All residents care plans were reviewed for to identify those with interventions for edema. DON and MDS Coordinator ensured that residents with edema interventions had orders placed on the eMAR for documenting of elevation of edematous lower extremities. Nursing staff were educated to the importance of elevation of edematous lower extremities as ordered and documenting. Any residents who may develop edematous extremities have the potential to be effected. DON or designee will review edema monitoring daily x 1 week, then weekly x 4 weeks and report findings to the QA committee.	

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F 684	Continued From page 19 morning and removed at bedtime. Provider orders, dated 7/27/22, also indicated to elevate legs twice daily. Chart if refuses. R9's plan of care, printed on 7/27/22, indicated an inability to walk and was receiving restorative nursing services; had potential for alteration in cardiac function related to HTN and coronary artery disease (CAD), required application of tubi-grips in morning, removal at bedtime daily, and elevation of legs and feet if edema present. Daily weights from 6/28/22-7/27/22 showed an 8.8 lb (pound). weight increase in 29 days; on 6/28/22 R9 weighed 188.5 lbs., on 7/27/22 R9 weighed 197.3 lbs. Physician visit note, dated 6/8/22, indicated R9 was seen on nursing home rounds; provider noted during visit chest congestion and wheezing, weight gain and weight pain, boarder line hypoxia with oxygen saturation 90%, edema to BLE's; plan to increase lasix medication from 10 mg daily to 30 mg daily. During observation, on 7/25/22 at 7:03 p.m., R9 was sitting in a wheelchair, had gripper socks (non-skid sock) applied to very swollen feet, feet were firmly on flooring. Compression stockings (snug-fitting, stretchy sock that gently squeezes leg), ordered was not observed at that time. When interviewed by phone, on 7/26/22 at 8:11 p.m., family member (FM)-A indicated awareness of swelling to R9's feet, thought swelling had worsened recently due to heart failure condition. FM-A stated R9 was on a sodium restricted diet, prescribed Lasix with no recent adjustments to dosage, was to wear compression stockings and	F 684		

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F 684	Continued From page 20 elevate feet to try to reduce fluid. FM-A admitted R9 was not always compliant with medical advice given per facility staff, staff would always contact him if R9 refused cares or had a change in medical condition,but had not been contacted per facility staff in months of any new recent medical changes or refusal in care. During an interview, on 7/27/22 at 9:22 a.m., nursing assistant (NA)-A indicated awareness of edema to R9's bilateral lower extremities (BLE's). NA-A stated she had noticed R9's edema to left lower extremity (LLE) was worse than right lower extremity (RLE). NA-A indicated staff applied compression stockings to BLE's every morning and recommended R9 lie down to elevate BLE's daily after breakfast and lunch to try to reduce edema;. NA-A indicated R9 refused to lie down, wanted to be up during day for activities. When interviewed, on 7/27/22 at 9:41 a.m., NA-B indicated awareness of edema to R9's BLE's, treatment was to apply compression stockings to her BLE's and elevate her feet when she was in bed. During an observation and interview on 7/27/22 at 11:20 a.m., R9 was observed sitting in wheelchair in her room; ace wraps were applied to BLE's, gripper socks over feet, feet firmly on flooring. Bilateral feet appeared swollen, right foot more swollen than left foot. R9 was asked if she noticed more swelling in feet recently, she stated she had; was upset one of her medications had been increased about a month ago because of the increase in swelling. R9 stated she wore "stockings" to help with edema, indicated staff had not recommended for her to put her feet up during the day, but would if they asked her to.	F 684		

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F 684	Continued From page 21 During interview on 7/27/22 at 11:59 a.m., licensed practical nurse (LPN)-A indicated awareness of edema to R9's BLE's, aides responsible to obtain daily weight and report to licensed nursing staff. LPN-A reviewed R9's weight over past month in electronic medical record (EMR), and confirmed weight increase should've been reported to physician per facility protocol. LPN-A stated to reduce R9's edema, compression stockings are applied daily and R9 was supposed to elevate BLE's a couple times per day, but R9 often refused. LPN-A tried to verify in R9's EMR completion or refusal of elevation of BLE's, could not find record of that. During an observation, on 7/27/22 at 12:57 p.m., R9 was in wheelchair in her room, eating lunch served on tray table. R9's bilateral foot appeared swollen, bilateral foot firmly placed on flooring of room. On 7/27/22 at 12:59 p.m., NA-A was asked if R9 had been offered to lie down in bed to elevate her feet, NA-A stated R9 had not been offered elevation of BLE's yet today, stated R9 would let staff know when she wanted to lie down and elevate feet. On 7/27/22 at 1:00 p.m., NA-C was asked if R9 had been offered to lie down in bed to elevate her feet, NA-C indicated was still in training and following NA-A, but they had not offered R9 elevation of BLE yet today. While interviewed, on 7/27/22 at 1:05 p.m., the director of nursing (DON) indicated awareness of R9's edema to BLE's, was care planned to have tubi-grips applied for compression daily. The	F 684		

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	245572	A. BUILDING _____ B. WING _____	07/28/2022

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F 684	Continued From page 22 DON stated R9 was supposed to lie down after breakfast and lunch to elevate BLE's, typically was in bed for elevation a few times per day, nursing staff ensuring that. The DON indicated R9's weight had always fluctuated between mid-180's-mid-190's since admission, was seen per provider on rounds 6/8/22, lasix dosage increased to 30 mg at that time; furthermore, dietician had been monitoring R9's weight closely and was started on thiamine for edema on 7/25/22. The DON stated R9 had not had any new or worsening changes in medical condition that she was aware of. During an observation and interview on 7/27/22 at 2:00 p.m., R9 observed to be lying in bed; head of bed, bilateral knee, bilateral thigh elevated slightly, feet on mattress pad and non-elevated. The DON was brought into R9's room for observation, on 7/27/22 at 2:10 p.m. The DON initially thought BLE's were elevated, realized elevation was under bilateral thigh only. DON confirmed bilateral foot very edematous and should've been elevated to reduce edema per care plan, DON was then noted to raise R9's bottom foot of bed to elevate bilateral foot. A policy on edema prevention and treatment was requested, received a policy on change of condition only.	F 684		
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	F 692		9/9/22

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F 692	Continued From page 23 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 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based observation, interview and record review the facility failed to assess and reassess residents needs related to care plan interventions, monitor the effectiveness and coordinate care among an interdisciplinary team for 1 of 1 resident (R126) who had weight loss and poor nutritional status. Findings include: R26's quarterly minimum data set (MDS) assessment dated 7/8/22, identified R26 as having severe cognitive impairment. R26 required supervision, oversight, encouragement, cues and set up with eating. The assessment further identified R26 as having a weight loss of 5% or more in the past month or 10% or more in the past 6 months. R26's weight was 114 pounds. R26's nutritional assessment dated 4/5/22, indicated R26 is on a mechanically therapeutic	F 692	F692-It is the practice of Colonial Manor to assure residents with weight loss are reassessed for potential additional interventions in attempt to avoid continued weight loss. R26 was reassessed by the RD on 8/15/2022. The RD reviewed all residents weights on 8/29/22 to identify an potential residents affected by the deficient practice. The interim CDM will reassess R26 likes and dislikes with resident as able and/or family and staff. Staff that assist all residents needing encouragement to eat will be educated on the importance of continually providing cues and encouragement and offering other foods that are available if there is a dislike of	

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F 692	Continued From page 24 altered diet. R26 has dementia and does refuse to eat. R26 requires assistance to eat at meals, but is often sleepy. R26 leaves 25% of food at most meals. Weight is 117.4# (usual body weight is 130#). R26 has broken natural teeth with no swallowing problems. R26's nutritional risk is "14" which means high risk for weight loss. Food intakes meet 26-75% of estimated needs. No referrals at this time, due to weight loss being unavoidable. R26's care plan dated 4/21/22, identified R26 as having alteration in nutritional needs and identified as having malnutrition, related to dementia and mood disorder. This has impacted R26's intakes. R26 receives a regular diet, thickened liquids and nutritional supplement. Interventions included; monitor R26 for any eating problems related to chewing and swallowing difficulties, supervise or assist as she allows with eating, provide set up help, provide encouragement to eat and cues during the meal, monitor changes in the residents ability to feed self, record intakes, monitor for signs of malnutrition and report to provider as needed, monitor weight weekly, provide a comfortable eating environment and monitor food and fluid intakes with each meal. R26's physicians order dated 6/6/22, includes an order for a regular diet with nectar thickened liquids and a 4 ounce house supplement bid (scheduled at 10:00 a.m. and at 4:00 p.m.). The supplement is given 1 1/2 hrs before dinner and supper. R26's mini nutritional assessment dated 7/6/22, indicated R26 has poor food intakes and is malnourished. R26 weighs 113.5 lbs.	F 692	food. To assure that all residents food preferences are identified the Dietary Manager or designee will continue to gather food preferences upon admission, at quarterly care conferences and as needed. All current residents food preferences will be reviewed to assure this identification is current and up to date The MD will be updated again to inform of R26 weight loss, interventions tried and being tried. The RD will review R26 weekly for one month and then every other week for 2 months in attempt to identify any further weight loss and/or recommendations for potential additional interventions. The RD or designee will continue to review and monitor at risk residents on a monthly or more frequent basis, as needed . The RD reviews all residents weights and intakes on a monthly basis. If there are newly identified residents with significant weight changes are identified the RD will add to their high risk monitoring list. Resident identified as having significant wt. change are then are put-on a high risk list and monitored monthly, or more frequently, for improvements and interventions and are re-evaluated at least monthly to ensure the appropriate interventions are in place. Audits will be completed by DON or	

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F 692	Continued From page 25 Review of the current licensed dietician (LD) notes dated 7/9/22, indicated R26 is on a regular diet and intakes are 0-50%. Resident receives a nutritional house supplement which provides 440 kcal's. R26 refuses staff assistance with eating and refuses supplement. R26 is malnourished and the decline in weight may be unavoidable. Weights will be monitored and changes made as needed. R26's weights in the past 6 months: 2/1/22-129.3 lb. (pounds) 3/1/22-124.7 lb. 4/12/22 115.4 lb. 5/3/22-112.5 lb. 6/6/22-114.1 lb 7/26/22 111.1 lb. R26's provider visit progress note dated 7/19/22, identifies R26 with a diagnosis of non-intentional weight loss and dementia with declining functional status. The note did not address the resdient's current significant weight loss related to contributing factors or interventions attempted to prevent further weight loss. Observation on 7/25/22, at 6:18 p.m. R26 was sitting at the supper table with 3 other residents and 1 staff person. There were 4 (unidentified) staff in the dining room during the supper meal. R26 had a word game she was working on, while at the table. The supper meal was served, but R26 continued to work on the word game through the supper meal. R26 made no attempt to eat and just took 2 sips of milk. Nursing assistant (NA)-H and NA-I observed R26 focused on her word game and not eating. NA-H and NA-I made no attempt to encourage or re-direct R26 to eat.	F 692	designee to assure staff are encouraging R26 and other residents requiring encouragement to eat and/or offering other foods available as an alternate. QA committee will review residents with weight loss or at high risk as identified by Interim CDM and/or RD monthly.	

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F 692	Continued From page 26 An alternate food choice was not offered to the resident, if R26 may not have liked what was served. Observation on 7/26/22, at 12:00 p.m. R26 was at the dinner table. R26 was working on a word puzzle in her lap. R26's meal was served, but made no attempt to eat. R26 continued to be focused on the word game. NA-K was sitting at the same table through the entire meal, assisting another resident. NA-K made no attempt to redirect R26 from the word game or encourage her to eat. An alternate food choice was not offered to the resident, if R26 may not have liked what was served. Observation on 7/27/22, at 12:00 p.m. R26 was at the dinner table. R26 was working on her word game in her lap. R26 was served her meal, but continued to be focused on the word game. R26 sat through the entire meal without eating. NA-K assisting another resident, at the same table. NA-K made no attempt to encourage R26 to eat or cue her in anyway. An alternate food choice was not offered to the resident, if R26 may not have liked what was served. Although, R26's weight loss had been identified and indicated may be unavoidable, R26 was not assessed further to R26's likes, dislikes, distraction related to the word puzzle or if R26 was provided encouragement and cues at meals that could have affected the residents eating and weight loss. In addition, the provider had been informed through fax communication related to R26 identified as being malnourished. A nutritional supplement had been ordered and given prior to the meal time, which could possibly affect the residents appetite.	F 692		

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F 692	Continued From page 27 Interview on 7/27/22, at 6:30 p.m. NA-H indicated the staff stopped encouraging R26 to eat during meals because she will refuse anyway. NA-H indicated he was unsure if R26 had specific food likes. Interview on 7/27/22, at 12:30 p.m. NA-J indicated R26 will bring a word game to the dinner table most of the time. NA-J indicated if staff do not try and encourage her to leave it in her room, she will refuse to let it go at the dining room table. NA-J indicated R26 does have specific food likes, that include food that is served at the breakfast meal. Interview on 7/27/22, at 12:45 p.m. NA-K indicated R26 does have specific food likes, that include food that is served at the breakfast meal, but was unsure if these foods had ever been offered at other meals. Interview on 7/28/22, at 10:00 a.m. the facility MDS coordinator indicated the facility currently did not have a dietary manager/director. The MDS coordinator stated R26 may have not gotten assessed for food likes and dislikes that could be served at meals, to attempt to get her to eat. Interview with the director of nursing (DON) on 7/27/22, at 1:30 p.m. stated R26 often refuses to eat and receives a nutritional supplement, but often refuses to drink. The DON indicated R26 should continue to be encouraged to eat at meals and provide assist. The DON further confirmed R26 had not been assessed for food likes and dislikes. The DON indicated R26's provider was aware of the resident being malnourished.	F 692		

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F 692	Continued From page 28 Attempted to contact the facility licensed dietician on 7/28/22, at 9:00 a.m., but unsuccessful. Facility Policy Weighing and Weight Changes of Residents, revised 4/22, included; (1) All new admissions are weighed daily x 7 days. Weights are taken by nursing staff and evaluated by the certified dietary manager (CDM) or dietary manager (DM) with a call or fax to RD/MD as needed. (2) After 7 days, weekly weights will begin unless there is an MD order for on-going daily weights. (3) Weekly weights are taken by nursing staff and entered into eMAR. CDM/DM or RN/LPN will review weights and request for reweighs if there is a change of+/- 3 lbs. in a week or if eMAR flags weight. (4) If reweigh confirms a weight change of+/- 3 lbs., daily weights will be requested by RN/LPN or CDM/DM for 7 days to observe resident's weight. (5) The CDM/DM will evaluate for significant weight gains and losses. If significant weight changes are documented, CDM/DM will report to the RD to review. (6) The RD views monthly weights for those with significant weight losses or gains, residents who are at risk, and residents with pressure ulcers. (7) If weight loss is confirmed and the resident's meal intakes are more than 50%, the CDM/DM will report to the RD/MD with confirmation of significant weight change. The CDM/DM will continue to observe resident's weight for another week before starting interventions, unless recommended to do otherwise by RD/MD. (8) If weight loss is confirmed and the resident's meal intakes are less than 25-50%, the CDM/DM will report to the RD/MD with confirmed weight loss. The CDM/DM will start interventions.	F 692		

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F 755	Continued From page 29	F 755		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their system for medication reconciliation was adequate to ensure	F 755	F755 - It is the practice of Colonial Manor that drug record systems are adequate to ensure timely identification of potential	9/2/22

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F 755	Continued From page 30 timely identification of loss or diversion of discontinued narcotic medications for 1 of 1 medication room. Findings include: On 7/27/22, at 8:56 a.m. the medication room was reviewed with licensed practical nurse (LPN)-A. LPN-A indicated they reconcile narcotic medications at change of shift including discontinued narcotic medications. LPN-A showed a "Discontinued Controlled Medication" loose sheet of paper that is used to reconcile the scheduled medications at the change of shift. There were 6 entries that included: 7/14/22 Tramadol 50 mg, 26 tablets; 7/18/22, Tramadol 50 mg 37 tablets; 7/18/22 Tramadol 50 mg 38 tablets; 7/19/22 Morphine Sulfate 100 mg/5 ml 28.75 mls; and 7/20/22 Hydrocodone 5-325 mg 15 tablets. LPN-A indicated pharmacy comes and destroys the medications and verified there would be no way of knowing if someone had removed medications and the loose sheet of paper. During interview on 7/18/22, at 9:55 a.m. director of nursing (DON) confirmed there was a potential for diversion with the loose sheet of paper used to reconcile the medication. A policy and procedure last revised/reviewed 4/2022 titled "Narcotic- Counting/Destruction Of" included: Narcotic controlled substance should be counted, and order written in the bound unit narcotic book.. When any controlled substance is discontinued and removed, it is placed in the locked box in the cupboard in the medication room, and documented on the discontinued medication	F 755	loss or diversion of discontinued narcotic medications. On 7-27-22, DON reviewed and updated the policy titled, Narcotic-Counting/Destruction to state, When any controlled substance is discontinued and removed, it is placed in the locked box in the cupboard in the med room and documented in the bound narcotic book. Policy was also updated to state that Two nurses will destroy scheduled II-V substances by placing the medications in RxDestroyer. Until the medication is destroyed, the medication will be counted between shifts when the nurses perform the narcotic counts" On 7-27-22, DON updated the policy titled, Medications: Destroying to state, Schedule II, III and IV controlled drugs must be destroyed by 2 nurses. The DON discussed with the consultant pharmacist on the changes on 8/3/2022,consultant pharmacist was in agreement with the changes. All facility nurses were educated on these policy changes by email on 7-27-22. On 7-27-22, DON and nurse destroyed all currently discontinued controlled substances that were located in the locked box and that were documented on the loose sheet of paper. All d/c controlled substances were disposed of in the RxDestroyer. All residents with discontinued controlled substances had the potential to be effected. DON or designee will audit discontinued	

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F 755	Continued From page 31 flowsheet, and signed by two nurses. The resident's name, prescription number, medication name, dose and count are documented on the flowsheet. The facility's rounding pharmacist will destroy scheduled II-V substances on monthly visits with the nurse. Until the rounding pharmacist arrives, the medication will be counted between shifts when the nurses perform the narcotic counts.	F 755	controlled substances weekly x 4 weeks, then monthly x 2 months. Results will be reported to the QA committee.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		9/2/22

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F 756	Continued From page 32 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consultant pharmacist failed to identify missing drug level monitoring for 1 of 5 residents (R7); who were reviewed for unnecessary medications, psychotropic medications, and medication regimen review. Findings include: R7's face sheet, printed on 7/28/22, identified R7 had a diagnosis of vitamin D deficiency (nutrient needed for building and maintaining healthy bones), disorder of thyroid. R7's physician orders, printed on 7/28/22, indicated R7 received vitamin D3 1000 IU (units) by mouth once daily for vitamin D deficiency, and levothyroxine 125 mcg by mouth once daily for disorder of thyroid. R7's care plan indicated diagnosis of hypothyroidism, intervention to monitor lab work per MD standing orders and notify MD of lab results. R7's laboratory results requested, received on	F 756	F756-It is the practice of Colonial Manor to assure that resident's TSH levels are followed up on as ordered by the physician. On 7-29-22, R7's TSH level and Vitamin D were drawn. On 8-3-22, the consultant pharmacist reviewed all resident records to ensure lab work is completed as ordered. The facility's RN Case Manager reviewed all resident lab orders to ensure lab work has been completed as ordered. To ensure that this deficient practice does not occur the facility created a LAB tab in the Emar system and placed all current lab orders and any new lab orders that arrive in the future will be added as an order with a date that will alert staff of lab due in the Emar. Education has been provided to licensed nurses to understand the new lab alert tab	

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	245572	A. BUILDING _____ B. WING _____	07/28/2022

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

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F 756	Continued From page 33 7/28/22, indicated a thyroid stimulating hormone (TSH) level was drawn on 5/19/21, level was reported at 1.35 and within normal range, recommended TSH every year (yearly) and was overdue since 5/19/22. Lab results requested did not indicate a vitamin D level had been drawn. No current TSH level and vitamin D level was found in the medical record. R7's consultant pharmacist recommendations from 7/12/21 until 7/12/22 were reviewed. No recommendation for a vitamin D level or TSH level was made by the consultant pharmacist. When interviewed, on 7/28/22 at 8:12 a.m., registered nurse (RN)-A indicated consultant pharmacist should have noticed R7 needed to have a vitamin D level drawn, orders for lab draws came from consultant pharmacist or physician. RN-A stated R7 was seen per dietician on 11/23/21, recommendation made to decrease dosage of vitamin D, physician reviewed dietician's recommendation and signed orders on 11/24/21, physician did not address checking vitamin D level at that time. RN-A indicated she keeps track of all resident lab draws, aware of facility standing order to check TSH level yearly. RN-A stated a TSH level should've been completed for R7 in May '22, admitted she missed that during review of resident lab tracking. The director of nursing (DON) was present during discussion with RN-A and confirmed R7 had not had a vitamin D level drawn since admission on 11/6/20, TSH not drawn since 5/19/21, both labs should've been drawn. During a phone conversation with consultant pharmacist on 7/28/22 at 9:42 a.m., consultant pharmacist indicated when reviewing medication	F 756	in the Emar. All residents with lab orders have the potential to be effected. DON or designee will audit labs weekly x 3 months to ensure that lab work is being completed as ordered. Results of the audits will be shared with the QA committee and discontinued as appropriate after 3 months of audits.	

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F 756	Continued From page 34 regimen, evaluation for lab draws were assessed between her and facility registered nurse (RN)-A. Consultant pharmacist stated she was not able to determine if R7 was due for any lab draws, was not able to look in computer system at that time, and would check and contact surveyor later that afternoon. A phone message was left by consultant pharmacist, on 7/28/22 at 11:40 a.m., consultant pharmacist indicated regarding TSH level for R7 she had missed that, TSH was on standing order sheet and should've been drawn. Consultant pharmacist indicated since R7 was taking a very low dose of vitamin D, and would not recommend checking a vitamin D level. Facility policy and procedure, titled "Pharmacy Consultant," revised 4/22, included the consultant pharmacist will conduct a monthly drug review report for each resident at the facility; the consultant pharmacist shall be responsible for, but not limited to, the following: quality assurance review of pharmaceutical services including drug monitoring procedures, adequate laboratory monitoring of a drug effect (when pertinent).	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		9/2/22

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F 757	Continued From page 35 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure laboratory monitoring was completed to prevent complications and ensure therapeutic dosing for 1 of 1 resident (R7) who received levothyroxine (a medication given for thyroid disorder). Findings include: R7's face sheet, printed on 7/28/22, identified R7 had a diagnosis of thyroid disorder. R7's physician orders, printed on 7/28/22, indicated R7 received levothyroxine 125 mcg by mouth once daily for disorder of thyroid. R7's care plan indicated diagnosis of hypothyroidism, interventions included to administer medications per MD orders, evaluate/record/report effectiveness/adverse side effects, monitor lab work per MD standing orders and notify MD of lab results. R7's laboratory results requested, received on	F 757	F757-It is the practice of Colonial Manor to assure that resident's TSH levels are followed up on as ordered by the physician. On 7-29-22, R7's TSH level and Vitamin D were drawn. On 8-3-22, the consultant pharmacist reviewed all resident records to ensure lab work is completed as ordered. The facility's RN Case Manager reviewed all resident lab orders to ensure lab work has been completed as ordered. All lab orders have been placed on a newly created task tab in the eMAR. All residents had the potential to be effected. DON or designee will audit labs weekly x 3 months to ensure that lab work is being completed as ordered. Results of the audits will be shared with the QA committed for 3 months and discontinued as appropriate.	

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F 757	Continued From page 36 7/28/22, indicated a thyroid stimulating hormone (TSH) level was drawn on 5/19/21, level was reported at 1.35 and within normal range, recommended TSH every year (yearly) and was overdue since 5/19/22. No current TSH level was found in the medical record upon review. When interviewed, on 7/28/22 at 8:12 a.m., registered nurse (RN)-A indicated she kept track of all resident lab draws, was aware of facility standing order to check TSH level yearly. RN-A stated a TSH level should've been completed for R7 in May '22, admitted she missed that during review of resident lab tracking. The director of nursing (DON) was present during discussion with RN-A and confirmed R7 had not yet had a TSH level drawn and should have, as last TSH level was drawn 5/19/21. During a phone conversation with consultant pharmacist on 7/28/22 at 9:42 a.m., consultant pharmacist indicated when reviewing medication regimen, evaluation for lab draws were assessed between her and facility registered nurse (RN)-A. Consultant pharmacist stated she was not able to determine if R7 was due for any lab draws, was not able to look in computer system at that time, and would check and contact surveyor later that afternoon. A phone message was left by consultant pharmacist, on 7/28/22 at 11:40 a.m., consultant pharmacist indicated a TSH level for R7 had been missed, facility had standing order sheet to draw TSH levels, TSH level should've been drawn. Facility policy for medication regimen review requested but not received.	F 757		

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F 761	Continued From page 37	F 761		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerator observed in use for medication storage. This had potential to affect all 27 residents who resided at the facility. Findings include:	F 761	F761 □ It is the practice of Colonial Manor to assure that controlled substances are stored per regulatory guidance. On 8-3-22, the QA committee, pharmacist, and Medical Director discussed to remove the vial of lorazepam 2mg/mL from the e-kit medication list.	8/3/22

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F 761	Continued From page 38 During observation and interview on 7/27/22, at 8:56 a.m., licensed practical nurse (LPN)-A unlocked the medication room located behind the nurses station. The refrigerator was not locked. LPN-A opened refrigerator and inside on the bottom shelf was lorazepam 2 mg/ml, stored in a removable box titled nail polish pad remover along with promethazine suppositories. LPN-A indicated the lorazepam is reconciled at each medication count but has always been stored in the unlocked refrigerator like it currently is. During interview on 7/28/22, at 9:55 a.m., the director of nursing (DON) indicated she was not aware lorazepam needed to be stored in a separate box that is permanently affixed to the refrigerator and double locked. Facility policy titled Narcotic - Counting/Destruction of last reviewed and revised April 2022 included: -Policy is to provide accurate regulation and maintenance of controlled substances. -If there is a controlled medication in the refrigerator, including E-kit controlled substances, it is to be reconciled daily by the licensed nurse. It may be written in the bound narcotic book or placed on the MAR for count verification -Controlled substances for the E-kit will be stored in the narcotic lock box in the med room and will be reconciled when completing the narcotic counts between shifts.	F 761	The lorazepam 2mg/mL vial was removed, and no controlled substances are stored in the medication fridge in the locked med room. All residents had the potential to be effected. QA committee reviewed change at the most recent quarterly Medical Director QA meeting on 8-3-22.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/9/22

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F 812	Continued From page 39 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired food were identified and removed, date opened containers of food stored in one of three kitchen refrigerators, bread shelve, and walk-in freezer. This had the potential to affect all 31 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 7/25/22 at 3:15 p.m., with director of nursing (DON), observed food items in stand-up refrigerator, bread shelf, and walk-in freezer that were not dated or marked and/or were expired. The DON indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators and freezers should be gone through daily to check for expired	F 812	F812-It is the practice of Colonial Manor to ensure that food is properly labeled and removed upon expiration. No residents were directly affected, however all residents had the potential to be affected. During the week of 7/25/22 DON removed all identified items and disposed of the unmarked and/or expired items. On 8/1/2022 the Interim Certified Dietary Manager that began with Colonial Manor was informed on the deficient practice. The CDM and DON reviewed the policy on labeling and expired foods and updated it as needed. Education was provided to dietary staff on	

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F 812	Continued From page 40 or damaged food. The DON indicated if any food or drink is not dated when opened, it should be removed immediately, all left over food should be used within a few days or discarded. The following items were observed during tour: Stand-up refrigerator: 1.. sliced cheese wrapped in facility tin foil; approx. ¼ full; not dated/marked, no expiration date 2. cut-up pineapple pieces in facility container; approx. ½ full; not marked/dated, no expiration date 3. sliced turkey in facility zip-lock bag; approx. ¼ full; dated on bag 7/7/22; no open or expiration date marked 4. sliced turkey in facility zip-lock bag; approx. ¼ full; not marked/dated; no expiration date 5. shredded cheese- appeared dried, clumped together; approx. ¼ full; expiration date on bag 6/8/22 6. sliced cheese; approx. 20 slices; not marked/dated, no expiration date 7. shredded mozzarella cheese in facility zip-lock bag- appeared moist, clumped together; approx. ¾ full; not marked/dated, no expiration date 8. sliced swiss cheese in facility zip-lock bag- appeared clumped together; approx. ½ full; not marked/dated, no expiration date 9. Roseli low-moisture part-skim mozzarella cheese- appeared moist, clumped together; approx. ½ full; expiration date on bag 5/10/22 Walk-in freezer: 1. bag of waffles- observed open to air; approx. ½ full; not marked/dated; no expiration date 2. Monarch smooth sliced medium carrots; approx. ¾ full, not marked/dated, no expiration	F 812	8/18/22 regarding the policy on labeling foods with open dates and when to throw expired foods. The meeting minutes will be placed in a communication binder in the kitchen for all staff to review. The CDM will audit the freezer, refrigerators and bread shelf weekly to assure items are being labeled properly and that expired foods are are thrown timely for 3 months or until resolved. Results will be shared with the quarterly QA committee	

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F 812	Continued From page 41 date 3. potato wedges- observed open to air; approx. ¼ full, not marked/dated, no expiration date 4. shredded hash browns- observed open to air; approx. ¼ full; not marked/dated, no expiration date Bread shelf next to stove: 1. hot dog buns- observed to have mold on edge of one bun; approx. ½ full; not marked/dated, no expiration date on bag 2. hot dog buns- observed to have mold on top of one bun; full bag; not marked/dated, no expiration date on bag Facility policy and procedure, titled "Food Storage," reviewed 12/21, policy included food will be stored in an area that is clean, dry, and free from contaminants, and by methods designed to prevent contamination or cross contamination. Procedure included, food items will be stored on shelves, food will be stored a minimum of 6 inches above floor, racks and other storage surfaces will be clean and protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.), leftover food will be stored in covered containers or wrapped carefully and securely- each item will be clearly labeled and dated before being refrigerated, leftover food is used within 7 days or discarder per the 2017 federal food code. Facility policy and procedure, titled "Food Procurement and Facility Gardens," consisted of food and nutrition services staff will be responsible for handling harvested foods properly once they reach the kitchen including safe storage, thorough cleaning, and appropriate handling for preparation, service, and storage of	F 812		

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F 812	Continued From page 42 leftovers.	F 812		
F 908 SS=C	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in freezer ceiling vent was maintained in a safe and functional manner. This had the potential to affect all 31 residents who resided within the facility. Findings include: An initial walk through of the kitchen was completed on 7/25/22 at 3:15 p.m., observed the ceiling vent located in the walk-in freezer to have icicles hanging downward with a large amount of ice sitting on top of a box labeled taco flour shells on shelving, box appeared wet with freezing formation. During an observation and interview of walk-in freezer on 7/28/22 at 10:38 a.m., maintenance (M)-A and the director of nursing (DON) were shown the ceiling vent, with icicles hanging downward with a large amount of ice sitting on top of a box labeled taco flour shells on shelving, box appeared wet with freezing formation. M-A indicated awareness of vent with ice formation, stated condensation had built up to coils in vent and became iced due to air leaking inside from a torn off strip on bottom of door, kept door from shutting air-tight. M-A stated torn off strip to	F 908	F908 It is the practice of Colonial Manor to assure that freezer vent is maintained properly. The boxes of food were identified having ice on top was removed and thrown on 7/29/2022. On August 1st, 2022 The Director of Maintenance repaired and cleaned ceiling vent to assure proper functioning of the freezer and to avoid ice build-up. Education was provided to Director of Maintenance on timely repairs and to have routine inspection of working freezer/cooler equipment. Dietary staff were also educated on 8/18/22 on the importance of being observant of ice build-up in freezer and other identifying factors in the walk-in coolers/freezers to potentially identify any malfunction of the equipment. The Director of Maintenance will add a monthly visual check to the walk in freezer/cooler to identify any abnormal findings for potential interruptions in the	9/9/22

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F 908	Continued From page 43 bottom of walk-in freezer door had been replaced approximately a week and a half ago, but ceiling vent hadn't been checked for further cleaning and repairs since door strip had been replaced. M-A indicated he should have checked ceiling vent for further cleaning and repairs, was on his to-do list, but hadn't gotten to yet. The Food Storage Policy, dated 2017, directed the staff to ensure all refrigerator and freezer units were kept clean and in good working condition at all times.	F 908	proper functioning of the freezer/cooler.	

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	245572	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2022**

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COLONIAL MANOR NURSING HOME	**403 COLONIAL AVENUE** **LAKEFIELD, MN 56150**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/27/2022. 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 IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2022**

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K 000	Continued From page 1 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 is a 1 story building, with partial basement The building was constructed in 1969, being one story with partial basement, and was determined to be of Type II (111) construction. An addition was constructed in 1979, one story with no basement, and was determined to be of Type I (111) construction. Another addition was constructed in 1999, one story with no basement,	K 000		

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K 000	Continued From page 2 and was determined to be of Type II (111) construction. Because the 1969 building and the 1979 and 1999 additions are of same type construction allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler systems. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain points of exit in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, and 7.1.7. This deficient finding could have a patterned impact on the residents within the	K 271	Discharge From Exits It is the consistent practice of Colonial Manor to ensure all exits are free from being a trip hazard. The North Wing East Exit door vertical displacement was	9/2/22

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K 271	Continued From page 3 facility. Findings include: On 07/27/2022, between 11:00 AM to 03:00 PM, it was revealed by observation that the egress to grade outside of the North Wing - East Exit Door had a vertical displacement greater than one-half inch presenting a fall and trip hazard. An interview with the Maintenance Director verified this finding at the time of discovery.	K 271	repaired on August 16th, 2022 by the Director of Maintenance. All other exits will be inspected by Director of Maintenance and repaired as needed by September 2, 2022. Administrator and/or designee will ensure compliance.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1 and 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/27/2022, between 11:00 AM to 03:00 PM, it was revealed during documentation review that the documents presented had no indication or legend to identify if/when the 90 min annual testing was completed.	K 291	Emergency Lighting -It is the consistent practice of Colonial Manor to ensure all battery operated emergency lights operate properly and documented acknowledging proper operation. The light located outside of the Physical Therapy office was repaired on 7/28/2022. All other facility battery operated emergency lights were checked for proper working on August 15th, 2022. The 90 minute annual testing was also completed on 8/15/2022 by the Director of Maintenance. All residents residing in the facility have the potential to be effected by the alleged	9/2/22

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K 291	Continued From page 4 2. On 07/27/2022, between 11:00 AM to 03:00 PM, it was revealed by observation that the emergency light located outside of Physical Therapy did not function upon testing An interview with the Maintenance Director verified this finding at the time of discovery.	K 291	practice. To ensure that the alleged deficient practice does not recur Battery operated lighting will be tested and documented each month and logged monthly. The annual 90 minute test will completed and recorded annually. Education was provided to the Director of Maintenance regarding the importance of the completion and documentation of these checks. The Administrator will review and sign the log monthly for 3 months to ensure the g battery operated lighting is tested as operational and documented each month. Administrator will audit in one year to assure the annual 90- minute test is completed.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintian portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.1, 6.1.3.3.1, 7.2.4, This deficient finding could have a widespread impact on the residents within the facility.	K 355	Portable Fire Extinguishers □ It is the consistent practice of Colonial Manor to ensure portable fire extinguishers are accessible accordance with NFPA10. 1.The portable fire extinguisher located in physical therapy and in the basement boiler room that were obstructed were corrected after survey exited the building. Yellow marking tape was placed in front of	9/2/22

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K 355	Continued From page 5 Findings include: 1. On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed by observation that in the following locations fire extinguishers were access obstructed: Physical Therapy Area - exercise bike blocking access; Basement Boiler Room - items in front of and around extinguisher 2. On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed during a review of available documentation that no inspection and maintenance records were available for review An interview with the Maintenance Director verified this finding at the time of discovery.	K 355	both extinguishers to identify to all staff that nothing shall be placed in that location. 2. The maintenance director created a log sheet of all fire extinguishers located in the building and will complete inspection. All residents have the potential to be affected by the alleged practice. Education was provided to therapy staff and to the Director of Maintenance. 2.Education was provided to Director of Maintenance on the need to document all fire extinguisher inspections. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur. 1. Education will be provided to all staff to ensure they understand the importance of not obstructing a fire extinguisher. Audits will be completed weekly for 1 month to ensure they are not blocked. Then the audits will be down every other week for two months. The audits will include the therapy office and boiler room, along with two other fire extinguishers in the building for 3 months. The findings will be share with the QA and if determined compliancy, audits shall be discontinued. 2.Director of Maintenance shall send a copy of the next annually inspected fire inspection log to the Administrator.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie	K 374		9/2/22

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K 374	Continued From page 6 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4. These deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed by observation that upon testing of the smoke barrier door assembly at the N Wing that the door assemble exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke An interview with the Maintenance Director verified this finding at the time of discovery.	K 374	Subdivision of building Spaces Smoke Barriers It is the practice of Colonial Manor that all smoke barrier door assembly have less than 1/8 inch gap to not allow smoke. The North Wing smoke barrier door assembly was corrected by placing self-adhesive seal vertically from the top of the door to the bottom. All residents have the potential to be affected by the alleged deficient practice. All other smoke barrier doors will be inspected by the Director of Maintenance to assure the compliance. Any issues found will be corrected and brought before the monthly QA committee for review.	

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K 374	Continued From page 7	K 374	The smoke barrier door assemblies will be inspected and logged annually by the Director of Maintenance	
K 712 SS=C	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 document review and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4, 19.7.1.6, 4.7.2, and 4.7.6. These deficient finging could have a widespread impact on the residents within the facility. Findings include: On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that a fire drill had been conducted for 1st shift - 1st quarter 2022. An interview with the Maintenance Director verified this finding at the time of discovery.	K 712	The facility failed to conduct a fire drill in the first quarter of 2022. The Director of Maintenance was Educated by Administrator the importance of drills being held consistently each month. All residents have potential to be impacted by this deficient practice. Drills will be held monthly by Maintenance Director or designee . A Monthly log will be kept by the Director of Maintenance to easily identify what shift is due for a drill each month. The Director of Maintenance will submit a copy of the log 2x year, at the 6 month marks, to the	9/2/22

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K 712	Continued From page 8	K 712	Administrator, to assure no missed drills have occurred.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15.2, and 7.2.1.15.4, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed during documentation review that the documentation presented for review was generic in content and did not provide details	K 761	Maintenance Inspection and Testing Fire Doors It is the policy of the facility to perform fire door inspections per NFPA standards. No residents were directly affected by the deficient practice, but have the potential to be affected. The Maintenance Director was educated the on the requirement of annual fire door inspections. The facility preventative maintenance program will be updated to include annual fire door inspections per NFPA Standards. The Director of Maintenance will inspect all doors	9/9/22

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K 761	Continued From page 9 associated to the multipoint inspection and testing of the door assemblies. An interview with the Maintenance Director verified these findings at the time of discovery.	K 761	requiring inspection. To assure ongoing compliance The Director of Maintenance will perform annual fire door inspections per NFPA requirements. Annual fire door inspections will be completed by on 9-9-2022. The completion of fire door inspections will be reported to administrator and QA for review. The Director of Maintenance is responsible for compliance with this requirement.	
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. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 914		9/9/22

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K 914	Continued From page 10 by: Based on a review of available documentation and staff interview, the facility failed to record details associated to electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1.4, 6.3.4.2.1.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed by a review of available documentation that the documentation presented for review did not clearly identify or provide confirmation that the physical condition, ground continuity, polarity, and ground retention force of each individual outlets in resident rooms had been completed. An interview with the Maintenance Director verified these findings at the time of discovery.	K 914	It is the practice of Colonial Manor to assure outlets in resident rooms are checked annually. The documentation form was updated to include the physical condition, ground continuity, polarity, and ground retention force. No Resident was directly affected by the deficient practice. Education was provided to the Director of Maintenance on the requirement of resident room receptacles being inspected annually. All receptacles will be inspected by the Director of Maintenance with all required tests. The facility recognizes that all residents have the potential of being affected by the deficient practice. Facility Maintenance Director will maintain documentation in Life Safety Binder and will use an updated form that will identify the physical condition, ground continuity, polarity, and ground retention force. Maintenance Director was given education by Administrator on the regulation requiring all the checkpoints of the outlet. Director of Maintenance will bring any identified issues to the monthly QA&A meeting for further review and will submit outlet inspection to administrator to verify all room inspections are completed.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/9/22

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K 918	Continued From page 11 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview the facility failed to maintain,	K 918	It is the practice of Colonial Manor to assure generator testing is completed for	

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K 918	Continued From page 12 test and inspect the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9 through 8.4.9.7, and 8.3.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed during documentation review that that most recent full annual inspection of the generator was completed in 2018. 2. On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed during documentation review that no records were available for review to confirm that last 36 month - 4 hour run and load-bank test. An interview with the Maintenance Director verified these findings at the time of discovery.	K 918	proper functioning. No residents were directly impacted by the deficient practice The facility recognizes that all Residents and employees have the potential of being affected by the deficient practice Education was provided to Director of Maintenance the importance to have this on the calendar to assure the company has this test completed timely and is on their schedule. The Director of Maintenance has been in contact with vendor to schedule the annual inspection, complete the 4 hour run and load bank test and 3 year battery check. It is scheduled to be completed on 8/24/2022 Director of Maintenance will submit a copy of the completed paperwork to Administrator to assure testing was completed.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		9/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2022**

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COLONIAL MANOR NURSING HOME	**403 COLONIAL AVENUE** **LAKEFIELD, MN 56150**

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K 920	Continued From page 13 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the usage of power taps and extension cords per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed by observation that in the Activities Office an extension cord was in use and powering a power-strip. 2. On 07/27/2022 between 11:00 AM to 03:00 PM, it was revealed by observation in the Office Managers Office that an extension cord was powering a high-current appliance refrigerator. An interview with the Maintenance Director verified these findings at the time of discovery.	K 920	It is the practice of Colonial Manor to assure use of extension cords are not in use in the facility. No residents were directly impacted by the deficient practice. The facility recognizes that all Residents have the potential of being affected by the deficient practice Upon exit of survey, Director of Maintenance removed extension cords being used in activity office and managers office. They were replaced with an approved power strip. Director of Maintenance inspected all other areas of the building on 8/16/2022 in attempt to identify an other unapproved extension cords in the facility. Education will be provided to all staff on being observant while in resident rooms or other areas of the facility that the use	

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K 920	Continued From page 14	K 920	of extension cord is not allowed and if one is identified to let person in charge or Director of Maintenance aware.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: EJQ711

Dear Administrator:

The above facility was surveyed on July 25, 2022 through July 28, 2022 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, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00302	A. BUILDING: _____ B. WING _____	07/28/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/25/22, 7/28/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/22

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 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.	2 000		

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2 000	Continued From page 2 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		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to	2 505		8/24/22

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2 505	Continued From page 3 treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R15) who utilized a self-release belt as a restraint. Findings include Observation on 7/26/22, at 9:24 a.m. R15 was noted to be sitting in a wheelchair with a seat belt attached to wheelchair, and clipped around her waist. When asking R15 if she could release the belt, she shook her head "no". During this time, R11 was sitting calmly in her wheelchair and made no attempts to stand or move in her chair. Observation on 7/26/22, at 3:15 p.m. R15 was noted to be sitting in her wheelchair with a self-release belt attached to her chair. The belt was clipped around her waist. Nursing assistant (NA)-F asked R15 to unclip the belt. R15 was unable to do this. NA-F indicated for at least the past 2 years, R15 was unable to unclip the self-release belt. NA-F further indicated R15 had	2 505	Corrected	

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2 505	Continued From page 4 made no attempt to transfer self or even move in her chair independently. R15's quarterly minimum data set (MDS) assessment dated 5/27/22, identified utilizing a restraint in the wheelchair as well as an alarm. The MDS identified R15 as requiring extensive assistance with mobility and activities of daily living (ADL's). R15's brief interview mental status (BIMS) was a "3" (severe cognitive impairment) R15's mechanical device assessment dated 5/26/22, identified R15 as having muscle weakness, arthritis and Alzheimer disease. R15's posture is good, but is unsteady and utilizes a mechanical aid and 2 staff assist for transfers. R15's fall risk analysis assessment dated 5/26/22, identified no falls in the past 3 months. R15 has a self releasing belt alarm in the wheelchair and uses a body pillow when in bed for positioning. The assessment indicated the belt was utilized as a restraint, and had not been removed because R15's family requested the continued use R15's physical restraint assessment dated 5/26/22, identified R15 as utilizing a wheelchair self-release belt restraint, that she is unable to remove. Risks were reviewed with R15's family, but still requested the continued use of the restraint. Removal is discussed at each care conference. The restraint is released every 2 hours. R15 no longer attempts to transfer self or fall. R15's physician visit note dated 6/8/22, indicated R15 was observed sitting in a wheelchair with a restraint belt around her. The note indicated the family requested the restraint. The provider did	2 505		

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2 505	Continued From page 5 not address the use of the restraint, other than the family requesting the use. R15's care plan dated 6/21/22, identifies R15 as having a seat belt restraint when in wheelchair, related to weakness, falls and poor decision making. This is per family request, despite several staff request to have it removed. Review of the medical record indicated R15's self-release belt was first initiated on 5/31/13. At that time, R15 was assessed to be able to self-release the belt. On 6/7/18, R15 was assessed to not be able to release the belt. At this time, the belt was considered a restraint as assessed. The assessment further indicated even though the belt was considered a restraint, R15 continued to utilize per family request. Interview on 7/26/22, at 3:25 p.m. facility MDS coordinator confirmed the seat belt utilized by R15 was assessed as a restraint. The MDS coordinator indicated R15 had been unable to release the belt since 2018. The MDS coordinator indicated R15's belt restraint is discussed at each care conference with the residents family. The discussion includes the removal of the seat belt and review of the risks for continued use. R15's family has declined the removal. Interview on 7/27/22, at 10:30 a.m. NA-G indicated R15 has not attempted to transfer self for at least the past couple of years. NA-G further indicated she had been aware the seat belt on R15's wheelchair was a restraint, because she was unable to release the clip on the belt. Interview on 7/27/22, at 11:30 a.m. the administrator and DON confirmed R15 continued to utilize a self-release belt as a restraint since	2 505		

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2 505	Continued From page 6 2018, even though R15 is unable to release the belt. The administrator and DON further indicated there had been many discussions with R15's family, related to the risks of continued use of the restraint. R15's family continued to decline. The DON indicated R15 has had the self-releasing belt since 2013, because of continued self-transfer without assistance. R15 required assistance at that time due to weakness, but would not ask for help. This resulted in many falls. Facility policy Restraints revised on 4/22, indicates the policy is to promote and maintain the resident's independent physical functioning in medical situations which are life threatening. To protect the resident from injury and to ensure the physical safety of the resident or other residents. The policy procedures include: 1. Less restrictive safety devices will be tried before a restraint is applied. 2. When these measures fail, a positioning device/restraint may be applied to enable and promote greater functional independence. 3. The resident/resident representative or legal representative will be informed and must agree to its use. 4. The physician is contacted, and a specific order is obtained. The order must indicate the type, frequency, and duration of use. 5. Once a positioning device/restraint is identified as a mechanism to enable the resident to attain/maintain his/her highest level of physical, mental, psychosocial function, the Mobility/Restraints Assessment Evaluation and Care plan will be adjusted. 6. The care plan reflects that use of this device is periodically re-evaluated, at least quarterly, and efforts to discontinue its use are documented. 7. When a positioning device/restraint is deemed	2 505		

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2 505	Continued From page 7 appropriate, the restraint will be released every two hours and the resident will be repositioned. 8. Always apply a positioning device/restraint correctly. 9. Documentation of the device use will be reflected in the resident's chart in the location of the care plan and restraint assessment kept under the Assessment tab. 10. Emergency use of waist restraint or wheelchair belt restraint may be used if a resident is in an immediate threat to health or safety of self and/or others. A physician and resident representative/guardian will be notified of the application of restraint and further orders will be received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the use of physical restraints are not utilized when contraindicated. Ensure residents that are assessed and contraindicated for the use of physical restraints, do not utilize a physical restraint. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. The DON or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 505		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		9/9/22

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2 965	Continued From page 8 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 observation, interview and record review the facility failed to assess and reassess residents needs related to care plan interventions, monitor the effectiveness and coordinate care among an interdisciplinary team for 1 of 1 resident (R126) who had weight loss and poor nutritional status. Findings include: R26's quarterly minimum data set (MDS) assessment dated 7/8/22, identified R26 as having severe cognitive impairment. R26 required supervision, oversight, encouragement, cues and set up with eating. The assessment further identified R26 as having a weight loss of 5% or more in the past month or 10% or more in the past 6 months. R26's weight was 114 pounds. R26's nutritional assessment dated 4/5/22, indicated R26 is on a mechanically therapeutic altered diet. R26 has dementia and does refuse to eat. R26 requires assistance to eat at meals, but is often sleepy. R26 leaves 25% of food at most meals. Weight is 117.4# (usual body weight is 130#). R26 has broken natural teeth with no	2 965	Corrected	

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COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 9 swallowing problems. R26's nutritional risk is "14" which means high risk for weight loss. Food intakes meet 26-75% of estimated needs. No referrals at this time, due to weight loss being unavoidable. R26's care plan dated 4/21/22, identified R26 as having alteration in nutritional needs and identified as having malnutrition, related to dementia and mood disorder. This has impacted R26's intakes. R26 receives a regular diet, thickened liquids and nutritional supplement. Interventions included; monitor R26 for any eating problems related to chewing and swallowing difficulties, supervise or assist as she allows with eating, provide set up help, provide encouragement to eat and cues during the meal, monitor changes in the residents ability to feed self, record intakes, monitor for signs of malnutrition and report to provider as needed, monitor weight weekly, provide a comfortable eating environment and monitor food and fluid intakes with each meal. R26's physicians order dated 6/6/22, includes an order for a regular diet with nectar thickened liquids and a 4 ounce house supplement bid (scheduled at 10:00 a.m. and at 4:00 p.m.). The supplement is given 1 1/2 hrs before dinner and supper. R26's mini nutritional assessment dated 7/6/22, indicated R26 has poor food intakes and is malnourished. R26 weighs 113.5 lbs. Review of the current licensed dietician (LD) notes dated 7/9/22, indicated R26 is on a regular diet and intakes are 0-50%. Resident receives a nutritional house supplement which provides 440 kcal's. R26 refuses staff assistance	2 965		

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2 965	Continued From page 10 with eating and refuses supplement. R26 is malnourished and the decline in weight may be unavoidable. Weights will be monitored and changes made as needed. R26's weights in the past 6 months: 2/1/22-129.3 lb. (pounds) 3/1/22-124.7 lb. 4/12/22 115.4 lb. 5/3/22-112.5 lb. 6/6/22-114.1 lb 7/26/22 111.1 lb. R26's provider visit progress note dated 7/19/22, identifies R26 with a diagnosis of non-intentional weight loss and dementia with declining functional status. The note did not address the resdient's current significant weight loss related to contributing factors or interventions attempted to prevent further weight loss. Observation on 7/25/22, at 6:18 p.m. R26 was sitting at the supper table with 3 other residents and 1 staff person. There were 4 (unidentified) staff in the dining room during the supper meal. R26 had a word game she was working on, while at the table. The supper meal was served, but R26 continued to work on the word game through the supper meal. R26 made no attempt to eat and just took 2 sips of milk. Nursing assistant (NA)-H and NA-I observed R26 focused on her word game and not eating. NA-H and NA-I made no attempt to encourage or re-direct R26 to eat. An alternate food choice was not offered to the resident, if R26 may not have liked what was served. Observation on 7/26/22, at 12:00 p.m. R26 was at the dinner table. R26 was working on a word puzzle in her lap. R26's meal was served, but	2 965		

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2 965	Continued From page 11 made no attempt to eat. R26 continued to be focused on the word game. NA-K was sitting at the same table through the entire meal, assisting another resident. NA-K made no attempt to redirect R26 from the word game or encourage her to eat. An alternate food choice was not offered to the resident, if R26 may not have liked what was served. Observation on 7/27/22, at 12:00 p.m. R26 was at the dinner table. R26 was working on her word game in her lap. R26 was served her meal, but continued to be focused on the word game. R26 sat through the entire meal without eating. NA-K assisting another resident, at the same table. NA-K made no attempt to encourage R26 to eat or cue her in anyway. An alternate food choice was not offered to the resident, if R26 may not have liked what was served. Although, R26's weight loss had been identified and indicated may be unavoidable, R26 was not assessed further to R26's likes, dislikes, distraction related to the word puzzle or if R26 was provided encouragement and cues at meals that could have affected the residents eating and weight loss. In addition, the provider had been informed through fax communication related to R26 identified as being malnourished. A nutritional supplement had been ordered and given prior to the meal time, which could possibly affect the residents appetite. Interview on 7/27/22, at 6:30 p.m. NA-H indicated the staff stopped encouraging R26 to eat during meals because she will refuse anyway. NA-H indicated he was unsure if R26 had specific food likes. Interview on 7/27/22, at 12:30 p.m. NA-J	2 965		

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2 965	Continued From page 12 indicated R26 will bring a word game to the dinner table most of the time. NA-J indicated if staff do not try and encourage her to leave it in her room, she will refuse to let it go at the dining room table. NA-J indicated R26 does have specific food likes, that include food that is served at the breakfast meal. Interview on 7/27/22, at 12:45 p.m. NA-K indicated R26 does have specific food likes, that include food that is served at the breakfast meal, but was unsure if these foods had ever been offered at other meals. Interview on 7/28/22, at 10:00 a.m. the facility MDS coordinator indicated the facility currently did not have a dietary manager/director. The MDS coordinator stated R26 may have not gotten assessed for food likes and dislikes that could be served at meals, to attempt to get her to eat. Interview with the director of nursing (DON) on 7/27/22, at 1:30 p.m. stated R26 often refuses to eat and receives a nutritional supplement, but often refuses to drink. The DON indicated R26 should continue to be encouraged to eat at meals and provide assist. The DON further confirmed R26 had not been assessed for food likes and dislikes. The DON indicated R26's provider was aware of the resident being malnourished. Attempted to contact the facility licensed dietician on 7/28/22, at 9:00 a.m., but unsuccessful. Facility Policy Weighing and Weight Changes of Residents, revised 4/22, included; (1) All new admissions are weighed daily x 7 days. Weights are taken by nursing staff and evaluated by the certified dietary manager (CDM) or dietary manager (DM) with a call or fax to	2 965		

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2 965	Continued From page 13 RD/MD as needed. (2) After 7 days, weekly weights will begin unless there is an MD order for on-going daily weights. (3) Weekly weights are taken by nursing staff and entered into eMAR. CDM/DM or RN/LPN will review weights and request for reweighs if there is a change of+/- 3 lbs. in a week or if eMAR flags weight. (4) If reweigh confirms a weight change of+/- 3 lbs., daily weights will be requested by RN/LPN or CDM/DM for 7 days to observe resident's weight. (5) The CDM/DM will evaluate for significant weight gains and losses. If significant weight changes are documented, CDM/DM will report to the RD to review. (6) The RD views monthly weights for those with significant weight losses or gains, residents who are at risk, and residents with pressure ulcers. (7) If weight loss is confirmed and the resident's meal intakes are more than 50%, the CDM/DM will report to the RD/MD with confirmation of significant weight change. The CDM/DM will continue to observe resident's weight for another week before starting interventions, unless recommended to do otherwise by RD/MD. (8) If weight loss is confirmed and the resident's meal intakes are less than 25-50%, the CDM/DM will report to the RD/MD with confirmed weight loss. The CDM/DM will start interventions. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures related to assessment of nutritional needs, care plan interventions, monitoring for residents with poor nutritional status. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. The	2 965		

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2 965	Continued From page 14 DON or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired food were identified and removed, date opened containers of food stored in one of three kitchen refrigerators, bread shelve, and walk-in freezer. This had the potential to affect all 31 residents who were served food and beverages from the facility kitchen.	21095	corrected	9/9/22

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21095	Continued From page 15 Findings include: During interview and observation of kitchen on 7/25/22 at 3:15 p.m., with director of nursing (DON), observed food items in stand-up refrigerator, bread shelf, and walk-in freezer that were not dated or marked and/or were expired. The DON indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators and freezers should be gone through daily to check for expired or damaged food. The DON indicated if any food or drink is not dated when opened, it should be removed immediately, all left over food should be used within a few days or discarded. The following items were observed during tour: Stand-up refrigerator: 1.. sliced cheese wrapped in facility tin foil; approx. ¼ full; not dated/marked, no expiration date 2. cut-up pineapple pieces in facility container; approx. ½ full; not marked/dated, no expiration date 3. sliced turkey in facility zip-lock bag; approx. ¼ full; dated on bag 7/7/22; no open or expiration date marked 4. sliced turkey in facility zip-lock bag; approx. ¼ full; not marked/dated; no expiration date 5. shredded cheese- appeared dried, clumped together; approx. ¼ full; expiration date on bag 6/8/22 6. sliced cheese; approx. 20 slices; not marked/dated, no expiration date 7. shredded mozzarella cheese in facility zip-lock bag- appeared moist, clumped together; approx. ¾ full; not marked/dated, no expiration date 8. sliced swiss cheese in facility zip-lock bag- appeared clumped together; approx. ½ full; not	21095		

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21095	Continued From page 16 marked/dated, no expiration date 9. Roseli low-moisture part-skim mozzarella cheese- appeared moist, clumped together; approx. ½ full; expiration date on bag 5/10/22 Walk-in freezer: 1. bag of waffles- observed open to air; approx. ½ full; not marked/dated; no expiration date 2. Monarch smooth sliced medium carrots; approx. ¾ full, not marked/dated, no expiration date 3. potato wedges- observed open to air; approx. ¼ full, not marked/dated, no expiration date 4. shredded hash browns- observed open to air; approx. ¼ full; not marked/dated, no expiration date Bread shelf next to stove: 1. hot dog buns- observed to have mold on edge of one bun; approx. ½ full; not marked/dated, no expiration date on bag 2. hot dog buns- observed to have mold on top of one bun; full bag; not marked/dated, no expiration date on bag Facility policy and procedure, titled "Food Storage," reviewed 12/21, policy included food will be stored in an area that is clean, dry, and free from contaminants, and by methods designed to prevent contamination or cross contamination. Procedure included, food items will be stored on shelves, food will be stored a minimum of 6 inches above floor, racks and other storage surfaces will be clean and protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.), leftover food will be stored in covered containers or wrapped carefully and securely- each item will be clearly labeled and dated before being refrigerated, leftover food is used within 7	21095		

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21095	Continued From page 17 days or discarder per the 2017 federal food code. Facility policy and procedure, titled "Food Procurement and Facility Gardens," consisted of food and nutrition services staff will be responsible for handling harvested foods properly once they reach the kitchen including safe storage, thorough cleaning, and appropriate handling for preparation, service, and storage of leftovers SUGGESTED METHOD OF CORRECTION: The dietary director (DD) and licensed dietician (LD) could re-educate dietary staff on the policies and procedures related to labeling and storage of foods. The DD could conduct random audits to ensure compliance. The DM cold bring forth the audit results to the quality assessment (QA) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services	21530		9/2/22

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21530	Continued From page 18 and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the consultant pharmacist failed to identify missing drug level monitoring for 1 of 5 residents (R7); who were reviewed for unnecessary medications, psychotropic medications, and medication regimen review. Findings include: R7's face sheet, printed on 7/28/22, identified R7 had a diagnosis of vitamin D deficiency (nutrient needed for building and maintaining healthy	21530	Corrected	

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21530	Continued From page 19 bones), disorder of thyroid. R7's physician orders, printed on 7/28/22, indicated R7 received vitamin D3 1000 IU (units) by mouth once daily for vitamin D deficiency, and levothyroxine 125 mcg by mouth once daily for disorder of thyroid. R7's care plan indicated diagnosis of hypothyroidism, intervention to monitor lab work per MD standing orders and notify MD of lab results. R7's laboratory results requested, received on 7/28/22, indicated a thyroid stimulating hormone (TSH) level was drawn on 5/19/21, level was reported at 1.35 and within normal range, recommended TSH every year (yearly) and was overdue since 5/19/22. Lab results requested did not indicate a vitamin D level had been drawn. No current TSH level and vitamin D level was found in the medical record. R7's consultant pharmacist recommendations from 7/12/21 until 7/12/22 were reviewed. No recommendation for a vitamin D level or TSH level was made by the consultant pharmacist. When interviewed, on 7/28/22 at 8:12 a.m., registered nurse (RN)-A indicated consultant pharmacist should have noticed R7 needed to have a vitamin D level drawn, orders for lab draws came from consultant pharmacist or physician. RN-A stated R7 was seen per dietician on 11/23/21, recommendation made to decrease dosage of vitamin D, physician reviewed dietician's recommendation and signed orders on 11/24/21, physician did not address checking vitamin D level at that time. RN-A indicated she keeps track of all resident lab draws, aware of	21530		

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21530	Continued From page 20 facility standing order to check TSH level yearly. RN-A stated a TSH level should've been completed for R7 in May '22, admitted she missed that during review of resident lab tracking. The director of nursing (DON) was present during discussion with RN-A and confirmed R7 had not had a vitamin D level drawn since admission on 11/6/20, TSH not drawn since 5/19/21, both labs should've been drawn. During a phone conversation with consultant pharmacist on 7/28/22 at 9:42 a.m., consultant pharmacist indicated when reviewing medication regimen, evaluation for lab draws were assessed between her and facility registered nurse (RN)-A. Consultant pharmacist stated she was not able to determine if R7 was due for any lab draws, was not able to look in computer system at that time, and would check and contact surveyor later that afternoon. A phone message was left by consultant pharmacist, on 7/28/22 at 11:40 a.m., consultant pharmacist indicated regarding TSH level for R7 she had missed that, TSH was on standing order sheet and should've been drawn. Consultant pharmacist indicated since R7 was taking a very low dose of vitamin D, and would not recommend checking a vitamin D level. Facility policy and procedure, titled "Pharmacy Consultant," revised 4/22, included the consultant pharmacist will conduct a monthly drug review report for each resident at the facility; the consultant pharmacist shall be responsible for, but not limited to, the following: quality assurance review of pharmaceutical services including drug monitoring procedures, adequate laboratory monitoring of a drug effect (when pertinent).	21530		

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21530	Continued From page 21 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The DON or designee could develop a system to educate staff and the consulting pharmacist (CP) related to review of unnecessary medications and develop a monitoring system to ensure pharmacy reviews include medications that require laboratory measurements, for monitoring efficacy of the medication use. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If	21540		9/2/22

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21540	Continued From page 22 the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure laboratory monitoring was completed to prevent complications and ensure therapeutic dosing for 1 of 1 resident (R7) who received levothyroxine (a medication given for thyroid disorder). Findings include: R7's face sheet, printed on 7/28/22, identified R7 had a diagnosis of thyroid disorder. R7's physician orders, printed on 7/28/22, indicated R7 received levothyroxine 125 mcg by mouth once daily for disorder of thyroid. R7's care plan indicated diagnosis of hypothyroidism, interventions included to administer medications per MD orders, evaluate/record/report effectiveness/adverse side effects, monitor lab work per MD standing orders and notify MD of lab results. R7's laboratory results requested, received on 7/28/22, indicated a thyroid stimulating hormone (TSH) level was drawn on 5/19/21, level was reported at 1.35 and within normal range, recommended TSH every year (yearly) and was overdue since 5/19/22. No current TSH level was found in the medical record upon review. When interviewed, on 7/28/22 at 8:12 a.m., registered nurse (RN)-A indicated she kept track	21540	Corrected	

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21540	Continued From page 23 of all resident lab draws, was aware of facility standing order to check TSH level yearly. RN-A stated a TSH level should've been completed for R7 in May '22, admitted she missed that during review of resident lab tracking. The director of nursing (DON) was present during discussion with RN-A and confirmed R7 had not yet had a TSH level drawn and should have, as last TSH level was drawn 5/19/21. During a phone conversation with consultant pharmacist on 7/28/22 at 9:42 a.m., consultant pharmacist indicated when reviewing medication regimen, evaluation for lab draws were assessed between her and facility registered nurse (RN)-A. Consultant pharmacist stated she was not able to determine if R7 was due for any lab draws, was not able to look in computer system at that time, and would check and contact surveyor later that afternoon. A phone message was left by consultant pharmacist, on 7/28/22 at 11:40 a.m., consultant pharmacist indicated a TSH level for R7 had been missed, facility had standing order sheet to draw TSH levels, TSH level should've been drawn. Facility policy for medication regimen review requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and the consulting pharmacist, related to review of unnecessary medications. The DON could develop a monitoring system to ensure the consulting pharmacy reviews include medications that require laboratory	21540		

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21540	Continued From page 24 measurements, for monitoring efficacy of the medication use. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21540		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their system for medication reconciliation was adequate to ensure timely identification of loss or diversion of discontinued narcotic medications for 1 of 1 medication room. Findings include: On 7/27/22, at 8:56 a.m. the medication room was reviewed with licensed practical nurse (LPN)-A. LPN-A indicated they reconcile narcotic medications at change of shift including discontinued narcotic medications. LPN-A showed a "Discontinued Controlled Medication" loose sheet of paper that is used to reconcile the scheduled medications at the change of shift. There were 6 entries that included: 7/14/22 Tramadol 50 mg, 26 tablets; 7/18/22, Tramadol	21600	Corrected	9/2/22

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21600	Continued From page 25 50 mg 37 tablets; 7/18/22 Tramadol 50 mg 38 tablets; 7/19/22 Morphine Sulfate 100 mg/5 ml 28.75 mls; and 7/20/22 Hydrocodone 5-325 mg 15 tablets. LPN-A indicated pharmacy comes and destroys the medications and verified there would be no way of knowing if someone had removed medications and the loose sheet of paper. During interview on 7/18/22, at 9:55 a.m. director of nursing (DON) confirmed there was a potential for diversion with the loose sheet of paper used to reconcile the medication. A policy and procedure last revised/reviewed 4/2022 titled "Narcotic- Counting/Destruction Of" included: Narcotic controlled substance should be counted, and order written in the bound unit narcotic book.. When any controlled substance is discontinued and removed, it is placed in the locked box in the cupboard in the medication room, and documented on the discontinued medication flowsheet, and signed by two nurses. The resident's name, prescription number, medication name, dose and count are documented on the flowsheet. The facility's rounding pharmacist will destroy scheduled II-V substances on monthly visits with the nurse. Until the rounding pharmacist arrives, the medication will be counted between shifts when the nurses perform the narcotic counts. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or the consultant pharmacist could review and revise policies and procedures to include processes for monitoring and ensuring controlled substances are routinely reconciled by staff. The DON or the consultant pharmacist could perform random observational	21600		

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21600	Continued From page 26 audits to ensure compliance. The DON, consultant pharmacist or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 1 refrigerator observed in use for medication storage. This had potential to affect all 27 residents who resided at the facility. Findings include: During observation and interview on 7/27/22, at 8:56 a.m., licensed practical nurse (LPN)-A unlocked the medication room located behind the nurses station. The refrigerator was not locked. LPN-A opened refrigerator and inside on the bottom shelf was lorazepam 2 mg/ml, stored in a removable box titled nail polish pad remover along with promethazine suppositories. LPN-A	21610	Corrected	8/3/22

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21610	Continued From page 27 indicated the lorazepam is reconciled at each medication count but has always been stored in the unlocked refrigerator like it currently is. During interview on 7/28/22, at 9:55 a.m., the director of nursing (DON) indicated she was not aware lorazepam needed to be stored in a separate box that is permanently affixed to the refrigerator and double locked. Facility policy titled Narcotic - Counting/Destruction of last reviewed and revised April 2022 included: -Policy is to provide accurate regulation and maintenance of controlled substances. -If there is a controlled medication in the refrigerator, including E-kit controlled substances, it is to be reconciled daily by the licensed nurse. It may be written in the bound narcotic book or placed on the MAR for count verification -Controlled substances for the E-kit will be stored in the narcotic lock box in the med room and will be reconciled when completing the narcotic counts between shifts. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or the consultant pharmacist could review and revise policies and procedures to include processes for monitoring the security of controlled substances stored in the E-Kit. The administrator, DON or the consultant pharmacist could perform random observational audits to ensure compliance. The administrator, DON, consultant pharmacist or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21610		

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21610	Continued From page 28 (21) days.	21610		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walk-in freezer ceiling vent was maintained in a safe and functional manner. This had the potential to affect all 31 residents who resided within the facility. Findings include: An initial walk through of the kitchen was completed on 7/25/22 at 3:15 p.m., observed the ceiling vent located in the walk-in freezer to have icicles hanging downward with a large amount of ice sitting on top of a box labeled taco flour shells on shelving, box appeared wet with freezing formation. During an observation and interview of walk-in freezer on 7/28/22 at 10:38 a.m., maintenance (M)-A and the director of nursing (DON) were shown the ceiling vent, with icicles hanging downward with a large amount of ice sitting on top of a box labeled taco flour shells on shelving,	21685	Corrected	9/2/22

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21685	Continued From page 29 box appeared wet with freezing formation. M-A indicated awareness of vent with ice formation, stated condensation had built up to coils in vent and became iced due to air leaking inside from a torn off strip on bottom of door, kept door from shutting air-tight. M-A stated torn off strip to bottom of walk-in freezer door had been replaced approximately a week and a half ago, but ceiling vent hadn't been checked for further cleaning and repairs since door strip had been replaced. M-A indicated he should have checked ceiling vent for further cleaning and repairs, was on his to-do list, but hadn't gotten to yet. The Food Storage Policy, dated 2017, directed the staff to ensure all refrigerator and freezer units were kept clean and in good working condition at all times. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program is developed to accurately reflect ongoing preventative maintenance, scheduled or needed in the facility on a routine basis. The administrator could perform environmental rounds/audits periodically to ensure preventative maintenance is being done and equipment failure is being reviewed. The administrator, maintenance supervisor, or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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21855	Continued From page 30	21855		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect a resident's right to personal space privacy for 1 of 1 resident (R25), who voiced concern regarding resident (R7) coming into room on multiple occasions, touching personal belongings without permission. Findings include: R25's quarterly Minimum Data Set (MDS) assessment dated 7/1/22, indicated R25 had moderately impaired cognition and required extensive assistance of 1 staff for activities of daily living (ADL). The MDS also indicated R25 had diagnosis list including down syndrome (genetic developmental and intellectual disorder) and obesity. R7's quarterly MDS assessment dated 4/29/22, indicated R7 had severely impaired cognition. R7's care plan, printed on 7/28/22, indicated she required limited to extensive assist of 1 staff for ambulation. Furthermore, R7's care plan for	21855	Corrected	9/2/22

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21855	Continued From page 31 wandering included interventions consisting of; asking resident what they need or are looking for, conversing at resident's level, distraction with conversation or activity of interest to keep resident busy, ensuring needs are met and comfort level is facilitated, give simple directions, redirect as needed, taking resident for walk if weather permits, use of wanderguard system-check placement every shift and functionality daily and as needed. R7's face sheet, printed on 7/28/22, included diagnosis of; dementia with behavioral disturbance (a cognitive and behavioral disorder), anxiety (mood disorder), depression (mood disorder), insomnia (sleep disorder), restlessness and agitation, and irritability and anger. During an interview, on 7/25/22 at 5:50 p.m., R25 indicated was bothered by R7 always coming into room, tried to take personal items. R25 stated staff were aware of multiple incidents of R7 coming into room without permission, staff would come into room and escort R7 back to her room. When interviewed, on 7/27/22 at 9:09 a.m., nursing assistant (NA)-A indicated awareness of R7 going into R25's room, occurred 1-2 times in past couple of months, typically occurred during evening hours. NA-A stated when R7 went into R25's room, R7 would touch R25's personal belongings on nightstand and tray table, knew that bothered R25. NA-A indicated R7 would be escorted back to own room when staff noticed her in R25's room or R25 pressed call-light for staff assistance. NA-A stated was unaware of prevention interventions in place to keep R7 out of R25's room, staff provided re-direction when incidents occurred. During an interview, on 7/27/22 9:49 a.m., NA-B	21855		

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21855	Continued From page 32 indicated R25 reported two incidents regarding R7 coming into R25's room without permission approximately 1-2 weeks ago, discussed during nursing report, aware incidents caused agitation for R25. NA-B stated staff removed R7 from R25's room, increased safety monitoring for R7. NA-B indicated should having something in care plan to prevent R7 going into R25's room, as invasion of R25's privacy. When interviewed, on 7/27/22 at 1:35 p.m., the director of nursing (DON) indicated awareness of R7 occasionally wandering into residents' rooms, stated was unaware R7 wandering into R25's room was a bother for R25. Furthermore, the DON indicated awareness of R7's personal care needs with wandering, expectation was for staff to redirect and provide R7 with an activity. The DON indicated if any concerns with residents wandering became an issue for other residents, staff should have notified her of concerns, updated resident's care plan with new interventions. The DON confirmed R7 wandering into R25's room as an invasion of personal space and privacy. Facility policy and procedure, titled "Privacy," revised 4/22; indicated it was the policy to provide privacy and dignity of all residents; procedure included personal privacy and stated residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining residents room privacy from other residents. The DON or designee, could	21855		

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21855	Continued From page 33 implement measures to ensure residents privacy and perform observational audits to ensure compliance. The administrator or DON could educate staff on the policies and procedures related to resident privacy. The administrator, DON or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: (21) days.	21855		
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. 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	21880		9/2/22

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21880	Continued From page 34 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 interview and document review, the facility failed to ensure grievances related to noise levels were acted upon for timely resolution for 1 of 1 resident (R13) reviewed with ongoing complaints of not being able to sleep at night because of a neighbors loud TV noise. Findings include: During interview on 7/25/22, at 4:40 p.m. R13 stated he has not been able to sleep at night because his next door neighbor (R11) always has his TV on loud during the night. R13 indicated he reported his concern to the staff several weeks ago, but it still continues. R13 indicated there were no staff that followed up with him if his concerns were resolved. R13 further indicated he reported to the nursing staff recently, R11 continues to have the TV on and on high volume.	21880	corrected	

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21880	Continued From page 35 Review of the nursing progress note entry's indicated: -6/3/22, at 5:54 a.m. indicated R13 complained of R11's TV being to loud and asked staff to turn it down so that he could sleep. The note indicated a message was left for the facility social worker regarding R13's concerns. -6/13/22, at 5:26 a.m. indicated the staff noted R11's TV being very loud. The staff approached R11 and asked politely to turn it down. R11 became verbally upset and stated he was not being treated fairly and was upset. -6/14/22, at 3:03 a.m. indicated R13 complained of R11's TV being to loud and asked staff to turn it down. so that he could sleep. The note indicated a message was left for the facility social worker regarding R13's concerns. - 6/17/22, at 10:51 a.m. by the facility licensed social worker (LSW) indicated she met with R11 to discuss the TV volume related to other resident complaints. Discussed with R11 if he would be open to wearing headphones when watching TV. R11 stated he has a pair but does not know how to use. Staff will assist R11 with the headphones and until then R11 was asked to keep the volume on the TV on low. -6/18/22, at 3:45 a.m. indicated the staff could hear R11's TV from the nurses station. The staff went to ask R11 to turn his TV down. R11 became upset and started yelling stating I can watch my TV if I want. The staff told R11 he could watch his TV but needed to turn the volume down. The staff discussed with R11 he needed to close his door, turn his TV down or use his headphones, but he refused those options. R11 did eventually turn the TV down. On 726/22, at 2:00 p.m. facility grievances were requested for the past 3 months, but did not	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 36 included a grievance related to R13's complaint of the loud TV Interview on 7/27/22, at 11:45 a.m. the administrator indicated R13's concerns related to R11's TV being too loud had been discussed with R11. The administrator indicated a formal grievance report had not been completed and confirmed there had been no follow up with R13. The administrator indicated she had not been aware of the continued concerns R13 had with the TV and thought it had been resolved. The administrator indicated a grievance report should have been completed and a follow up with R13 per facility grievance policy guidelines. Facility policy Grievance revised on 1/22, indicated the facility grievance form shall be utilized to provide written documentation of any concern expressed by a resident or resident representative and to record the follow-up action taken and results thereof. Attach any additional information as needed to provide a complete and accurate investigation into the grievance. All staff will be educated regarding grievance procedures and resident's rights. Procedure: (1) Any resident, family member, or concerned persons with grievances should share this with the Grievance Official, Tricia Larson, LSW, Director of Social Services. (2) If not settled by informal discussion, a grievance should be written and given to the Administrator. (3) A grievance will then be shared with the Resident Care Review Committee, which is composed of the Administrator, Director of Social Services, and Director of Nursing. (4) A written response to the concerned person or persons will be made within 7 days.	21880		

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21880	Continued From page 37 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or social services (SS) director could review, revise policies and procedures related to resident grievances. The administrator and DON could conduct audits for compliance to ensure grievances are followed through and resolved. The administrator and DON could educate staff on the grievance policy and procedures.. The administrator, DON or designee could report audit findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		