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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JUB5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00982

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245552**
2.STATE VENDOR OR MEDICAID NO.
(L2) **570014100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2011**

6. DATE OF SURVEY **01/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 01/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245552

January 27, 2015

Mr. Charles Ness, Administrator
Colonial Manor Of Balaton
Highway 14 East PO Box 219
Balaton, Minnesota 56115

Dear Mr. Ness:

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

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

Effective January 1, 2015 the above facility is certified for:

33 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 12, 2015

Mr. Charles Ness, Administrator
Colonial Manor Of Balaton
Highway 14 East Po Box 219
Balaton, Minnesota 56115

RE: Project Number S5552026

Dear Mr. Ness:

On December 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 5, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2014, effective January 1, 2015 and therefore remedies outlined in our letter to you dated December 1, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245552	A. Building B. Wing	1/8/2015

Name of Facility	Street Address, City, State, Zip Code
COLONIAL MANOR OF BALATON	HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/01/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/01/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **01/01/2015**
ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **01/01/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	01/12/2015	22113	01/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/21/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245552	A. Building B. Wing 01 - MAIN BUILDING 01	1/5/2015

Name of Facility	Street Address, City, State, Zip Code
COLONIAL MANOR OF BALATON	HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 01/01/2015	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 01/01/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 01/01/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	01/12/2015	19251	01/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/19/2014	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

January 12, 2015

Mr. Charles Ness, Administrator
Colonial Manor Of Balaton
Highway 14 East PO Box 219
Balaton, Minnesota 56115

Re: Reinspection Results - Project Number S5552026

Dear Mr. Ness:

On January 8, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 8, 2015, with orders received by you on December 1, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00982	A. Building B. Wing	1/8/2015

Name of Facility	Street Address, City, State, Zip Code
COLONIAL MANOR OF BALATON	HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **01/01/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **01/01/2015**	ID Prefix **21000** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **01/01/2015**
ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp.** LSC	Correction Completed **01/01/2015**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **01/01/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	01/12/2015	22113	01/08/2015
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/21/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JUB5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00982

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245552**
2.STATE VENDOR OR MEDICAID NO.
(L2) **570014100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2011**

6. DATE OF SURVEY **11/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jodi Johnson, HFE NE II 12/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 1, 2014

Mr. Charles Ness, Administrator
Colonial Manor Of Balaton
Highway 14 East PO Box 219
Balaton, Minnesota 56115

RE: Project Number S5552026

Dear Mr. Ness:

On November 21, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 31, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 31, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by February 21, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING _____ B. WING _____	11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR OF BALATON	HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		1/1/15

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

Electronically Signed | 12/03/2014

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

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the plan of care related to an ongoing skin issue for 1 of 3 residents (R1) reviewed for non-pressure related skin conditions. Findings include: On 11/19/14, at 9:49 a.m. R1 was observed with a round scabbed area approximately 1 centimeter (cm) in diameter on the top of her right hand. R1 was unable to communicate how the skin condition occurred. R1's record was reviewed and a physician note dated 7/2/14 included: "She has been doing well except for she has been picking and anxious and then she will pick at her skin and right now has several open sores." Review of the physician note dated 11/12/14 included: "Skin: Does show an open sore on her right hand secondary to excoriation" (skin picking). Review of the care plan dated September 2014 identified a potential for impaired skin integrity with interventions including: monitor skin integrity with daily cares and weekly skin assessment by licensed staff. The care plan did not identify R1's issue related to picking at her skin. When interviewed on 11/21/14, at 8:47 a.m. the director of nursing (DON) stated that R1 had a "picking" problem and will pick at existing sores/scabs and reopen them. When the scabbed area located on the top of R1's right hand was observed with the DON, the DON confirmed this was one of the areas R1 had been	F 280	A. Care plan revised to show POC for skin issue for R1 on 11/28/14 B. Skin assessed on all residents and no other undocumented skin concerns were found on 12/1/2014. C. All residents will have POC initiated by the charge nurse when skin integrity is compromised. D. DON or designee will do audits of POC when all skin issues are presented. DON will report such results to QA. E. Completion Date. January 1st 2015	

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F 280	Continued From page 2 picking. The DON further stated the sore on the right hand had been present for at least 6 months. When interviewed on 11/21/14, at 9:12 a.m. licensed practical nurse (LPN)-A stated R1 had the noted area on top of the right hand for a long time due to a habit of picking and reopening the sore. LPN-A further stated the medical doctor recently commented on the area during a visit and advised the resident to leave it alone and not pick at it. LPN-A verified that R1's behavior related to picking her skin could increase the risk for infection and had not been included on the care plan and should have been addressed.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview,and document review the facility failed to monitor an ongoing abraded area to the right hand for 1 of 3 residents (R1) reviewed for non-pressure related skin conditions. Findings include: On 11/19/14, at 9:49 a.m. R1 was observed with	F 309	A. Charge Nurse assessed and documented the lesion on right hand. Also initiated monitoring of same daily for s/s of any changes to lesion on 11/21/2014. B. All current residents were assessed for any open areas, lesions and rashes.12/1/2014 C.Weekly skin assessments to be done on all residents. Nurses will document any	1/1/15

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F 309	Continued From page 3 a round scabbed area approximately 1 centimeter (cm) in diameter on the top of her right hand. R1 was unable to communicate how the skin condition occurred. R1's record was reviewed. Review of the physician note dated 11/12/14 included: "Skin: Does show an open sore on her right hand secondary to excoriation" (skin picking). Review of the weekly skin assessments/bath reports dated 11/18/14, 11/11/14, 11/4/14, and 10/21/14 revealed no skin concerns had been identified. Review of the treatment sheets for October 2014 and November 2014 did not include monitoring of the abraded area on R1's right hand Review of the care plan dated September 2014 identified a potential for impaired skin integrity with interventions including: monitor skin integrity with daily cares and weekly skin assessment by licensed staff. When interviewed on 11/21/14, at 8:47 a.m. the director of nursing (DON) stated that R1 had a "picking" problem and will pick at existing sores/scabs and reopen them. When the scabbed area located on the top of R1's right hand was observed with the DON, the DON confirmed this was one of the areas R1 had been picking. The DON further stated the sore on the right hand had been present for at least 6 months. When interviewed on 11/21/14, at 9:12 a.m. licensed practical nurse (LPN)-A stated R1 had the abraded area on top of the right hand a long time as she had a habit of picking at it and reopening it. LPN-A further stated the medical doctor recently commented on the area during rounds and advised the resident to leave it alone	F 309	and all skin that is not intact in the Nurses Notes. Initiate monitoring on the treatment record and use an incident report form to inform all attendees at IDT of issue. D. DON or designee will do random chart audits of resident skin issues weekly x 2 weeks, then monthly x 2. E. Completion date, January 1st 2015	

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F 309	Continued From page 4 and not pick at it. LPN-A stated being unaware if the area was being formally monitored as it was very visual being on her hand and was seen everyday. LPN-A reviewed the treatment sheets from 10/14 and 11/14 and verified the area on R1's right hand was not being monitored. LPN-A confirmed the skin picking could increase R1's risk for infection and like any other skin issue the area should have been monitored daily on the treatment sheet until healed and assessed weekly during the skin assessment. LPN-A further verified that R1's issues with picking her skin should have been addressed on the care plan. The policy/procedure titled, "Skin Care/Pressure Ulcer Care" reviewed and revised May 2011 included the following under "General Wound and Skin Care Guidelines": 17. Document type of wound, location, stage (if applicable), length, width, depth (in cm's), base drainage, periwound, tissue, and treatment of the wound weekly.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		1/1/15

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F 371	Continued From page 5 by: Based on observation, interview and document review the facility failed to properly clean the meat slicer to maintain food preparation equipment in a sanitary manner which has the potential to affect all 32 residents living in the facility. Findings include: During the initial tour of the dietary area on 11/18/14, at 11:30 a.m. the following observations were noted: The meat slicer was located in the paper storage area covered with a plastic cover. The meat slicer was noted to have a dried substance on the lower edge of the blade guard, the lower back surface of the slicing blade & around the 2 bolts which held the slicing guide. The dietary manager (DM) identified the substance as dried food debris. These noted areas would have direct contact with the meat as it is sliced. In addition, the meat comes in contact with the rear surface of the blade when sliced. The noted substance was a tan color and when touched by the DM, it flaked from the soiled surface areas. The DM verified the slicer had been considered clean as it was covered with a plastic cover and placed in the paper storage area until needed for subsequent meat slicing. The DM further indicated the meat slicer had most recently been used for slicing 2-3 weeks ago when ham or turkey meat was sliced and served. During an interview with the DM on 11/19/14, at 3:15 p.m. it was indicated the meat slicer had been cleaned. Upon further inspection, it was noted the blade guard was clean but the bolts attached to the slicing guide remained soiled with	F 371	A. Meat slicer was taken apart and thoroughly cleaned on 11/26/2014. B. Demonstration of cleaning given to dietary staff on 11/26/14. Retraining on cleaning policy done for all dietary staff by 12/1/2015.CDM will monitor cleanliness of meat slicer after and before each use per policy. C.Documentation log will be kept by CDM for QA to assess. 12/1/2014 Confirmed CD KS	

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F 371	Continued From page 6 a build up of food debris. The tan substance was evident around the bolts and extended underneath the slicer. The DM again confirmed the substance was food, rubbed it with her finger and the residue/debris flaked off from the slicer. The DM verified the slicer had been cleaned after the surveyor had identified the lack of cleanliness of the food equipment during the initial dietary tour on 11/18/14. However, the DM confirmed the meat slicer still required further cleaning as the noted areas had been missed. The DM stated the slicer had not yet been used since the lack of cleanliness had been identified. When a cleaning schedule was requested, the DM stated the slicer was cleaned after use and stored until needed so a schedule was not available. The DM indicated that she does provide training to the staff related to the proper cleaning of the meat slicer and and currently three staff have been trained to use this piece of equipment. During a subsequent observation of the breakfast meal on 11/20/2014, at 8:34 a.m. the DM confirmed the meat slicer had finally been cleaned properly per facility expectation and proper procedure. The DM confirmed the slicer had not been properly cleaned and subsequently stored for use. She confirmed the soiled areas of the meat slicer would have made contact with the meat as it was sliced when used. The DM further verified the identified areas noted on the meat slicer indicated the equipment had not been cleaned satisfactorily to promote proper sanitation during the preparation of food. The DM submitted a copy of the procedure titled Cleaning and Sanitizing Meat Slicer dated effective date: 8/93. The Policy: Meat Slicer will be cleaned and sanitized before and after each	F 371		

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F 371	Continued From page 7 use. Procedure: 1. Disassemble components and clean with a mild detergent and warm water solution. 2. Sanitize disassembled components 3. Allow parts to air dry 4. Carefully wash and rinse the top and bottom of the knife by wiping from the center of the knife outward. 5. Sanitize knife 6. Carefully replace the knife cover over the blade. Hold the knife cover with one hand while securely tightening the knife cover release knob with the other hand. 7. With the slicer table completely closed, wipe the slicer table off by starting at the knife and pulling toward you. 8. Clean and sanitize entire slicer 9. Allow to air dry. 10. Reinstall disassembled components after they are clean and dry. Make sure all knobs are tight 11. Cover slicer and holder and return to storage room. The Chef mate slicer manual under the heading of Disassembly & Cleaning lists: (to begin the cleaning procedure, disassemble the following components: 1. Food Chute: Remove the food chute by rotating the food chute release knob (k Fig.9-1) 2. Slice Deflector: The slice deflector can be removed by unscrewing the screw knob #1 (Fig. 9 -3). These are the two bolts identified as having food residue around and under them. (3.-7.) Detail the cleaning process 8. Reinstall all disassembled components after they are clean and dry. Make sure all knobs are	F 371		

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F 371	Continued From page 8 securely fastened.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide dental services which included a follow up dental appointment for 1 of 1 resident (R1) reviewed who had cognitive impairment and had identified dental needs. Findings include: During observation on 11/18/14, at 7:34 p.m. R1 was noted to be missing several teeth on the top front of her mouth. Review of the quarterly minimum data set (MDS) dated 9/11/14 indicated R1's diagnoses to include dementia. The brief interview for mental status (BIMS) revealed a score of "4" indicating severe cognitive impairment. Review of the care plan dated September 2014 included: "Dental exams as needed. Last dental exam 12/3/13 INHSS" (In House Senior Services dental provider). Review	F 412	A. Dental appointment made for R1 on December 11,2014. B. MDS nurses will review that all residents have current oral care services in place by Dec. 15, 2014 C. MDS nurses will review quarterly with completion of all residents MDSs, that oral services are kept current for all residents. D. MDS Nurses will report quarterly to DON via flow log that resident dental services are in place. DON will present this information at QA. E. Completion date, January 1st 2015	1/1/15

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F 412	Continued From page 9 of the patient progress notes from INHSS dental indicated R1 had an appointment on 8/13/13 and a follow-up appointment on 9/20/13 to have a cavity filled. The 9/20/13 progress note also indicated R1's next visit to be scheduled in 6 months. There were no further dental appointments available in the record of R1 nor was documentation available to indicate the family had declined the need for a follow-up dental appointment. When interviewed on 11/21/14, at 9:50 a.m. licensed practical nurse (LPN)-A confirmed R1 was not been examined since 9/20/13 for dental issues. LPN-A stated she was unaware that R1 and/or her daughter had been approached regarding a dental appointment this past year. LPN-A indicated she thought R1 had been seen by the local dentist since the last appointment dated 9/20/13 but no further information was available to review. LPN-A further verified the INHSS dental provider was no longer providing dental service to the facility. When interviewed on 11/21/2014, at 10:37 a.m. LPN-A reviewed the progress notes dated 9/20/13 from INHSS dental related to the recommendation for a follow-up dental visit in 6 months. LPN-A stated that since R1 was on medical assistance for insurance the appointment would need to be at least a year in between appointments. R1 would have had insurance available for payment in September 2014. LPN-A stated the facility decided in August 2014 to no longer have in-house dentist services and residents would utilize their own dentist. LPN-A was unable to produce evidence that a dental appointment had been offered or provided.	F 412		

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F 412	Continued From page 10 The policy titled, "Dental Services" revised May 2011 included: 1. Oral health services are available to meet the resident's needs. 3. Routine and emergency dental services are provided through: a. A contract agreement with a local dentist; b. Referral to the resident's personal dentist; c. Referral to community dentists; or d. Referral to other health care organizations that provide dental services. 4. Nursing coordinates with Health Unit Coordinators and Social Services in making dental appointments and transportation arrangements as necessary. 6. A list of dentists in the service area willing and able to provide routine or emergency dental services is available to nursing personnel.	F 412		

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	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 19, 2014. At the time of this survey, Colonial Manor of Balaton was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/03/2014

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
	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR OF BALATON	**HIGHWAY 14 EAST PO BOX 219** **BALATON, MN 56115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By E-Mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Colonial Manor of Balaton was constructed in 1973, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 33 beds and had a census of 32 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are	K 050		1/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR OF BALATON	**HIGHWAY 14 EAST PO BOX 219** **BALATON, MN 56115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all 32 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 11/19/2014, it was revealed during documentation review that the facility could only provide documentation of two fire drills in 2013-2014 not in accordance with NFPA 101 LSC Section 19.7.1.2. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection.	K 050	A. Quarterly fire drills will be done for each shift in every quarter. Fire drill was held on 11/23/2014 and also documented. Fire drills will be documented in flow log. B. Completion date January 1st 2015 C. These actions will be completed by environmental services director.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		1/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR OF BALATON	**HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 3 This STANDARD is not met as evidenced by: Based upon a review of available records and interview, testing of the digital alarm communicator transmitter (DACT) had not been conducted during each month of the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.6.1.4, and NFPA 70 (1999) and NFPA 72 (1999) and CMS policy. This deficient practice could adversely affect 32 residents. FINDINGS INCLUDE: On facility tour between 8:00 AM and 11:00 AM on 11/19/2014, during a review of available records provided by the facility Maintenance Supervisor, no documentation could be provided verifying the digital alarm communicator transmitter (DACT) was tested during 2013-2014 not in accordance with NFPA 70 and 72. 9.6.1.4	K 052	A. DACT will be logged for each month with dates and times. B. Completions date, January 1st 2015. C. This action will be completed by Environmental services director.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		1/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR OF BALATON	**HIGHWAY 14 EAST PO BOX 219** **BALATON, MN 56115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 32 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 11/19/2014, 1. A review of documentation and interview with the Maintenance Supervisor, revealed the facility failed to provide documentation of the quarterly fire sprinkler flow tests inspections required by NFPA 13(99) and NFPA 25(98). 2. A review of documentation also revealed that the main control valve was not supervised and no gauge for the anti-freeze system.	K 062	A. Quarterly flow test of sprinkler system will be done and documented. Have contacted Bros.Sprinkler company on 11/26/2014, for main control valve and to install gauge for antifreeze system. B. Flow test to be completed by January 1st 2015 C. Will be performed by Environmental Service Director.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
December 1, 2014

Mr. Charles Ness, Administrator
Colonial Manor Of Balaton
Highway 14 East PO Box 219
Balaton, Minnesota 56115

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5552026

Dear Mr. Ness:

The above facility was surveyed on November 18, 2014 through November 21, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245552	A. BUILDING ______ B. WING ______	11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR OF BALATON	**HIGHWAY 14 EAST PO BOX 219 BALATON, MN 56115**

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2000	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 November 18-21, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2000	RECEIVED DEC 10 2014 Minnesota Department of Health Marshall	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Electronically Signed	(X6) DATE 12/03/2014

Barb Hogeboom DON 12-3-14
Charlene Thiner ED 12-3-14