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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OQWO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00302

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/02/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)
13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Lois Boerboom, HFE - NE II — 07/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 07/11/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245572
July 10, 2018

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

Dear Ms. Goette:

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

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

Effective June 25, 2018 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

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

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

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 10, 2018

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

RE: Project Number S5572028

Dear Ms. Goette:

On April 23, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective April 25, 2018. (42 CFR 488.422)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 25, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 23, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 25, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on April 6, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on April 6, 2018. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty. (42 CFR 488.430 through 488.444)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 25, 2018 remain in effect. (42 CFR 488.417 (b))

On July 2, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 31, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 25, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 2, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 2, 2018.

In addition, we recommended to the CMS Region V Office the following actions:

- Civil money penalty, be imposed. (42 CFR 488.430 through 488.444)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 25, 2018 be discontinued effective July 2, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

As we notified you in our letter of April 23, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 25, 2018.

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OQWO

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/31/2018** (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)
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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

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

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17. SURVEYOR SIGNATURE Date :
Nicole Osterloh, HFE - NE II 06/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/10/2018 (L20)

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3. Both of the Above :
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05/01/1991
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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
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04-Other Reason for Withdrawal
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
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29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted

June 15, 2018

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

RE: Project Number S5572028

Dear Ms. Goette:

On April 23, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 6, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

On May 31, 2018, the Minnesota Department of Health and on May 11, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 3, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on April 6, 2018.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for

Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 30, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us

Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposed the following remedy:

- State Monitoring effective April 25, 2018 will remain in effect. (42 CFR 488.422)

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions effective June 25, 2018, will remain in effect. (42 CFR 488.41 (a))

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Colonial Manor Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 25, 2018. This prohibition remains in effect for the specified period even

though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 remedy be imposed:

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 July 6, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 6, 2018 (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
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	245572	A. BUILDING _____ B. WING _____	R 05/31/2018

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 The facility was previously found in compliance with Appendix Z Emergency Preparedness Requirements on 4/6/18.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit was completed on 5/29/18, 5/30/18, and 5/31/18 to determine the status of Federal deficiencies issued during a recertification survey exited on 4/6/18. The facility was found to have additional deficiencies which were identified. As a result, the facility has not achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The findings are delineated in this document. An Immediate Jeopardy (IJ) began on 5/29/18 at 6:18 p.m., when it was determined the facility failed to ensure the safety of 1 of 1 resident (R8) who smoked unsupervised while using oxygen, creating a highly flammable environment. The IJ was removed on 5/30/18, at 5:00 p.m., when the facility took steps to remove the immediate situation. Non-compliance remained at the lower scope and severity level of a D, which indicated no actual harm with potential for serious harm, injury, or death. An extended survey was conducted by the Minnesota Department of Health on 5/31/18. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/22/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	R 05/31/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 584} SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	{F 584}		6/18/18

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{F 584}	Continued From page 2 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the resident environment including 3 of 10 bathroom vents (located in Rooms #9, #10, and #13), were maintained in a clean manner. Findings include: During an environmental tour on 5/29/18 the following observations were made: (1) 12:30 p.m., the bathroom vent in Room #9 had a thick, gray covering of dust, dirt, and debris. (2) 12:33 p.m., the bathroom vent in Room #10 had a heavy thick, gray covering of dust and dirt debris with loose debris hanging from the vent slits. (3) 12:35 p.m., the bathroom vent in Room #13 had a heavy thick, gray covering of dust, dirt, and debris. Review of Bathroom Vents Inspection audits dated 5/1/18, 5/8/18, 5/15/18, 5/22/18, and 5/29/18, indicated Room's #9, #10, and #13's bathroom vents had been documented as having been cleaned. The facility's Tuesday Short Shift form, included a	{F 584}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Corrective action included all vent covers from all resident bathrooms were removed and washed with hot water by Environmental Services Director, and all excess dust/debris that had accumulated in the vents was removed/cleaned by the Environmental Services Director by wiping out/scrubbing with a cloth on 5/30/18. On 6/1/18, public restrooms, utility room on nursing floor area, and shower room vents were cleaned using the same process. On 6/1/18, the new policy and procedure was developed, and all housekeeping staff were verbally informed of the new vent cleaning process. On 6/4/18, a new vent cleaning and inspection form/checklist was developed to ensure	

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{F 584}	Continued From page 3 log of the weekly vent cleaning. All resident room bathroom vents in the facility were documented as having been cleaned on 5/1/18, 5/8/18, 5/15/18, 5/22/18, and 5/29/18. Review of Resident Room Vent Inspection document, indicated during the months of April and May of 2018, the maintenance manager had documented Rooms #9, #10, and #13 were clean, documenting "o.k." When brought to the administrator's attention on 5/29/18, she observed Rooms #9, #10 and #13 at 12:53 p.m., and concurred these bathroom vents were heavily soiled had did not appear to have been cleaned appropriately. Further interview on 5/29/18, at 1:05 p.m. with the administrator regarding the Bathroom Vents Inspection log, the Tuesday Short Shift Form procedure, and the Resident Room Vent Inspections by Department Director log, indicated she agreed Rooms #9, #10 and #13 had not been cleaned according to the documentation provided. The administrator stated the housekeeping supervisor was to have performed the above inspections and auditing of all resident room vents and the maintenance manager was to suppose to have overseen the completion.	{F 584}	documentation is completed and to ensure compliance with the Bathroom Vent Cleaning Policy. On 6/11/18, the bathroom vent cleaning was added to the Tuesday short shift responsibilities list. On 6/18/18, the housekeeping staff and housekeeping supervisor attended a hands-on bathroom vent cleaning meeting held by the Environmental Services Director to read/review the bathroom vent cleaning policy and watch the director perform vent cleaning. All housekeeping staff also performed vent cleaning. The Housekeeping Supervisor shall, on a weekly basis, visually inspect all bathroom ceiling vents to ensure the policy is being followed. Monthly, the Environmental Services Director shall inspect all bathroom ceiling vents to ensure the policy is being followed. Results of the inspections will be discussed by the QA committee at each meeting. The QA committee will make appropriate recommendations based on the results and any identified trends.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		6/25/18

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F 689	Continued From page 4 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safety of 1 of 1 resident (R8) who smoked unsupervised while inhaling oxygen supplied from a compressed oxygen (O2) canister attached to his wheelchair, resulting in an immediate risk of serious harm, injury or death from thermal burns for R8. The IJ began on 5/29/18 at 4:45 p.m., when R8 was observed to be smoking a cigarette unsupervised, while receiving oxygen from a small oxygen tank and it was determined the facility failed to ensure the safety R8 from this highly flammable situation. The Administrator (A) and Director of Nursing (DON) were informed of the IJ on 5/29/18 at 6:18 p.m.. The IJ was removed on 5/30/18 at 5:00 p.m., when the facility took steps to remove the immediate situation, however non-compliance remained at the lower scope and severity level of a D, which indicated no actual harm with potential for serious harm, injury or death. Findings include: During observation on 5/29/18, at 4:45 p.m. R8 was observed to be smoking in the parking lot of the facility's east entrance. The resident was observed to be smoking while wearing an oxygen nasal cannula and tubing that was connected to a 36 inch E-style oxygen compressed air tank, affixed to a holder on his wheelchair. During interview at 5/29/18, at 4:50 p.m. nursing	F 689	Resident was hospitalized on 6/15/18. Resident returned to facility on 6/18/18. Facility discussed resident's cognitive and medical condition and determined that resident was unsafe to leave facility grounds independently to smoke. Social Services Director visited with resident regarding inability to leave facility grounds independently and reviewed the facility's tobacco free campus policy with resident, reminding resident that smoking is not allowed. Resident verbalized agreement. New BIMS and new smoking assessment completed upon return from hospital. BIMS indicated a decline in cognitive function. Self administration of smoking assessment completed, and it was determined that resident does not qualify for independent smoking. Resident will be supervised when outside of building. If resident leaves facility grounds, resident must be signed out and accompanied by responsible person. To identify any other residents having the potential to be affected, facility will inform residents upon admission of facility's tobacco free campus policy. The facility will perform self administration of smoking assessment for any resident who smokes. The facility has not identified any other current resident with the potential to be affected. New smoking policy was developed and implemented on 6/18/18 to ensure that all residents who smoke are	

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F 689	Continued From page 5 assistant (NA)-A confirmed the observation of R8 smoking. She she stated he was known to smoke while wearing oxygen and while he was near the O2 tank. NA-A stated, "He signed a form stating it was o.k. to smoke with O2 [oxygen]". During interview on 5/29/18, at 4:55 p.m. A and the DON stated R8 was smoking in the parking lot and stated they were both aware he smoked while wearing his nasal cannula and tubing in the presence of his O2 tank. The administrator remarked, "Well is it even on?" The DON proceeded to go outside and check R8. During observation and interview on 5/29/18, at 4:57 p.m. R8 was still in the parking lot smoking. R8 stated he was just beginning to put out his cigarette on the ground when the DON and surveyor arrived. A loud hissing could immediately be heard coming from the proximity of the tank on the back of R8's wheelchair. The DON immediately turned the handle of the regulator switch on top of the canister and stated, "There, it's off now." The DON confirmed the oxygen tank had been running, and loudly hissing (indicating release of oxygen from the canister) upon arrival. The DON asked R8 why he didn't shut off his oxygen. R8 reported he thought he had, but commented he had problems getting it to completely shut off. R8's admission record indicated he'd been admitted to the facility on 9/23/16, with diagnoses including; chronic obstructive pulmonary disease, pneumonia, history of encephalopathy (brain disease, damage, or malfunction), bronchitis, post-traumatic stress disorder (PTSD), dependence on supplemental oxygen, heart disease, and nicotine dependence.	F 689	capable of doing so independently off campus in a manner that does not put themselves or others at risk. Results of smoking assessments to be discussed at QA committee meetings. QA committee will make appropriate recommendations based on the results and any identified trends.	

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F 689	Continued From page 6 Review of R8's medical record indicated a current Brief Interview for Mental Status (BIMS) dated 3/30/18, indicated a score of 9, indicating moderate cognitive impairment. Previous BIMS scores were 8 on 12/29/17, and 7 on 9/29/17, indicating coginitive fluctuations between severe and moderate cognitive impairment. The record also included a signed attestation statement from R8 dated 10/24/16, which included: (1) Colonial Manor is a tobacco free campus as of January 1, 2015. (2) I agree to not have cigarettes, lighters, matches, or any form of tobacco in my possession. (3) I agree not to use tobacco products on or off the facility grounds, including inside the facility. (4) As discussed at admission, due to my medical condition and medications, I agree to refrain from smoking at all times. Review of R8's current care plan included a note dated 6/22/17, indicating R8 had a history of making unsafe decisions with smoking. "Found to be placing cigarette butts under his w/c [wheelchair] cushion because he was told not to throw them out on peoples property in the community". A smokeless butt ashtray was to be given to R8 "independently when he leaves the facility grounds and brought back when he's finished. Resident aware that he needs to give ashtray to nurse when he returns and is not taken to room." Another note on the care plan dated 10/6/16, included: "The resident smokes daily. States he shuts off his oxygen when he smokes. Aware of the risk factors. Resident is independent with setting O2 liters [L] on his portable O2 tank.	F 689		

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F 689	Continued From page 7	F 689		

Puts liters (2-4 L) at whatever he feels he needs at the time."

Review of a faxed physician (pulmonologist) response on 10/23/17, indicated R8's "COPD stable on current program. recommend smoking cessation. F/U [follow up] only as needed".

Review of R8's 9/29/17, Assessment for Self Administration of Smoking indicated the criteria for smoking were:
(1) [R8] has no cognitive impairment: "No. See BIMS. Resident alert. Signs self out of facility when he smokes."
(2) [R8] does not use oxygen. Residents are never allowed to smoke with oxygen on: "Yes. resident reports visually noted to shut off O2 when he smokes".
(3) [R8] can identify appropriate areas to smoke-off property: "Yes."
(4) [R8] can effectively demonstrate safe smoking habits including safe and proper disposal of ashes and cigarettes: "Yes. Needs to take smokeless ashtray with him when he smokes."
(5) Resident has no history of unsafe smoking practices (No evidence of burn holes in clothing, finger burns, etc.): "No. H/O [history of] placing cigarette butts under w/c cushion. Safety discussed with resident."
A note in the middle of the form indicated, "Any area marked NO may disqualify the resident from independently smoking."
On the back of the form, comments were added for the next two quarterly assessment dates as follows:
(1) On 12/28/17: "No changes with plan of care (POC)."
(2) On 3/30/18: "Staff have discussed with resident tobacco free campus policy. resident

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F 689	Continued From page 8	F 689		

verbalized understanding. Continue with POC."

During interview on 5/29/18, at 5:25 p.m. the DON was asked how staff verify safety of R8 while smoking in the presence of O2. The DON stated R8 did not smoke on the property. "He goes uptown. [The social worker] (SW) does spot checks on him to verify he has his O2 shut off. She does it on an annual basis." The DON clarified R8 was known to smoke on or near the property. When asked if the SW followed R8 uptown to do smoking assessments, the DON stated the SW performed the assessments out front "on the street." The DON was "unsure" how the resident had been determined to be safe while he smoked in the presence of O2, and an O2 tank, with a history of unsafe smoking, and cognitive impairment.

Review of R8's 4/5/18 Care Conference Summary, indicated R8 had a BIMS of 9 indicating moderate cognitive impairment. Safety measures were identified as: "Making sure O2 is shut off with smoking." R8 was noted to be on continuous O2, and was "Reminded about smoking safety."

During interview with R8 at the time of the observation on 5/29/18 at 5:45 p.m., R8 stated he was aware he had an O2 canister on the back of his w/c. R8 stated he normally went across the street off the property to smoke, but stated, "today it was so hot I wanted to sit under the tree. If I get close to the corner, the cars will take me out." He recalled facility staff discussing risks of smoking in the presence of O2 with him and stated, "I usually shut it off but I've had some trouble with this new tank regulator." R8 also stated the tanks run empty a couple times per

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F 689	Continued From page 9	F 689		

day but said he has no set times of day when he is allowed out to smoke." R8 stated he sometimes went uptown, and if the weather was bad he just didn't go out. R8 also stated the nursing staff keep his cigarettes and stated he "field stripped" his cigarettes when smoking, meaning he smoked them all the way down to the filter. R8 stated he was not the only resident who smoked but stated he wasn't going to tell. He again stated, "There is something wrong with the regulator [on the O2 tank]. I've been after them for a month [to fix it]."

During interview on 5/29/18, at 6:00 p.m. registered nurse (RN)-A verified R8's O2 regulator needed to be changed as she thought it was leaking.

Review of R8's 2/6/18, therapy progress note indicated nursing staff reported R8 was caught over the weekend smoking inside the facility in the therapy entrance. "R8 opened the door and was blowing smoke outside."

A progress note from 5/5/18 indicated R8 had returned from the store with a yellow plastic bag. The note indicated the contents were not checked by licensed practical nurse (LPN)-A . R8 handed his lighter, ashtray and an empty pack of cigarettes to LPN-A. LPN-A asked R8 if he was aware there were no cigarettes left in the box. R8 agreed. After supper, R8 requested his cigarettes from LPN-A and became angry that she had no cigarettes. LPN-A asked R8 if he checked the yellow bag. R8 returned to his room. Upon returning to the nurses' station, R8 denied having found his cigarettes, but LPN-A observed R8 smoking outside the window.

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F 689	Continued From page 10	F 689		

A social worker (SW) note documented 5/16/18, indicated it had been reported to her R8 was smoking on the sidewalk outside her office. The SW had documented she'd told R8 he had to leave the property to smoke. "[R8] believed he was off property since he was on the edge of the sidewalk. [R8] went to the edge of the property to finish his cigarette."

During interview on 5/30/18, at 4:30 p.m. dietary aide (DA)-C stated she had seen R8 downtown smoking with his O2 on before and had reported it to the nursing staff.

During interview with physical therapist (PT)-F on 5/30/18, PT-F stated she was aware R8 had a history of unsafe smoking and had been caught inside the therapy department doors, blowing smoke outside while wearing his O2.

During interview on 5/31/18, R8's medical director (MD)-A stated he was not aware R8 had been smoking while using O2, near his O2 canister, or that R8 had a history of unsafe smoking. MD-A's stated,"He either shouldn't be smoking or he shouldn't be on oxygen."

Review of the facility's 1/1/15 Tobacco Free Campus policy, indicated the facility was tobacco free and residents were to be notified upon admission. There was no mention how residents were going to be assessed for safety, or if the facility would allow residents who smoked prior to admission to continue to smoke off the property.

John R. Hall, Jr., The Smoking Material Fire Problem, NFPA [National Fire Protection Association] Fire Analysis and Research Division, July 2013 indicates: "....7% of fatal victims of

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F 689	Continued From page 11 smoking-material fires who were themselves the smokers whose smoking materials started the fires were under treatment with medical oxygen. The combination of smoking and use of medical oxygen is so dangerous that it became the subject of one of the seven recommnded educational messages from the project: Smoking should not be allowed in a home where medical oxygen is used." Additionally, the article states "In an NFPA analysis of fires and burns involving home medical oxygen, smoking materials were inivolved in 73% of 2003-2006 thermal burns reported to hospital emergency rooms and involving home medical oxygen." The immediate jeopardy that began on 5/29/18 was removed on 5/30/18, at 5:00 p.m., when the facility took action to ensure R8's safety with smoking including requiring R8 to remove the oxygen tank prior to him leaving the campus, educating R8 and staff related to safe smoking practices, requring nursing to monitor and document R8's compliance with removing his oxygen prior to smoking, as well as assessing other residents who may smoke to ensure safe smoking practices. Noncompliance remained, however, at the lower scope and severity level of a D, which indicated no actual harm with potential for serious harm, injury or death.	F 689		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity	F 801		6/25/18

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F 801	Continued From page 12 and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not	F 801		

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 _____	R 05/31/2018

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 801	Continued From page 13 employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed ensure the contracted registered dietician, (RD)-A, appropriately assessed and intervened to ensure 3 of 3 residents (R3, R31, and R36) who were identified for weight loss, did not have continued or worsening weight loss. Additionally, 8 other residents (R5, R14, R16, R22, R23, R24, R26, and R28) had been identified by the facility for weight concerns, however, RD-A had failed to conduct an assessment. This had the potential potential for harm to affect all 34 residents in the facility.	F 801	Corrective action for the affected residents included RD completing an in house review of all facility residents on 6/6/18. On 6/6/18, RD conducted a consult/assessment for all residents who had been identified as having nutritional needs. Other residents with the potential to be affected will be identified by CDM/DM or Nursing through monitoring of weights and intakes. CDM/DM or Nursing will	

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F 801	Continued From page 14 Findings include: Record review of the clinical documentation related to nutrition and weight loss, and interview with staff, indicated there was no active involvement with RD-A to appropriately assess and intervene on behalf of the residents in the facility. RD-A had not been coming on site to the facility to conduct a complete assessment of the residents' nutritional needs. R31 and R36 had been identified as triggering for weight loss according to the Roster Sample Matrix, given to survey staff upon entrance and lacked an assessment completed by RD-A. The remaining residents, R5, R14, R16, R22, R23, R24, R26, and R28 were identified with weight concerns by DM-B after the 4/6/18 survey, but no mention of RD-A's involvement was noted. Review of the Contract for Dietetic Services dated 7/29/08 between the facility and RD-A indicated RD-A's role was to: (1) Monitor to assure compliance with all federal, state, and local regulations. (2) Advise [the facility] regarding residents' nutritional care assuring efficient, accurate, clinical documentation systems that identify residents with critical nutritional risks, and assures appropriate follow-up. (3) Act as a resource, providing up-to-date information and trends, relating to nutritional services in the long term care environment. (4) Maintain effective verbal and written communication, including reports, phone, and fax consultation. (5) Visit every 4-6 weeks. Additional visits or hours may be scheduled as needed. The facility was to assure staff was available to	F 801	notify RD or MD of all residents who have been identified as nutritionally at risk. RD will conduct in house review of residents every 8 weeks and make recommendations as needed. To ensure that the deficient practice does not recur, the CDM/DM will continue to contact RD as needed in between visits and will schedule in house visits by RD at a minimum of every 8 weeks as per revised contract. In order to monitor performance to make sure solutions are effective, CDM/DM will review weights and intakes weekly and report weights concerns to RD for recommendations and to conduct assessments as needed. DM will report findings at Quality Assurance meetings. The QA committee will review and assess need for changes in monitoring or policies based on reported findings at each meeting. The QA committee will make appropriate recommendations based on the results and any identified trends.	

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

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F 801	Continued From page 15	F 801		

meet with the RD-A on all regularly scheduled visits, and those visits were to be of adequate length to allow projects and goals to be completed.

Interview on 5/29/18 at 1:00 p.m. with the administrator (A) regarding RD-A's lack of visits and appropriate assessments on residents in the facility with weight loss indicated she saw no reason RD-A needed to be present in the facility. Staff could call her if needed. The contract between the facility and RD-A was from 2008 and the A inferred it was no longer relevant.

Interview on 5/29/18 at 3:30 p.m. with the director of nursing (DON) regarding the RD's lack of visits and appropriate assessments on residents in the facility indicated she agreed with A. Staff were to contact RD-A if they felt they needed consultation on weight loss. The facility's DM-B was not certified and was not a registered dietician. DM-B was reported to be assisted by CDM-A approximately three times per week to review residents in the facility.

Interview on 5/29/18 at 4:00 p.m. with RD-A concerning the lack of oversight, appropriate assessment, and continued weight loss in the facility indicated she has been a registered dietician since 1976. RD-A was unaware of the previous survey exiting 4/6/18. RD-A was also unaware the facility received a deficiency related to weight loss. RD-A reported to have visited the facility every 3-4 months until [contracted dietary department] took over the kitchen in the "last year or so." She has not been to the facility since. She relied on nursing staff to notify her and send her information. They could contact her if they have problems with low lab results or if they are doing

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F 801	Continued From page 16	F 801		

quarterly assessments etc. RD-A trained people to be her "eyes and ears." She had no way of knowing if they were "Not doing their job."

RD-A further stated she had no remote [off-site] access to the EMR. RD-A confirmed she had no way of viewing critical information located in each resident's EMR or paper chart. "The nurses make recommendations, I assume they are doing it." RD-A saw no reason to come to the facility. She would not come to the facility for any reason, unless told to by facility staff. She did no onsite assessment for new admissions, residents with a significant change, weight loss, or any other reason. "There were mistakes that were made. If a fax on a pressure ulcer [for example] doesn't come in for 3 days, that is critical. It's not my fault." RD-A stated she did not participate in the interdisciplinary team (IDT), nor was she part of the Quality Assurance Performance Improvement (QAPI) meetings whose responsibilities were to oversee the facility. She was unaware of how many residents were being monitored for weight concerns.

Review of the Food Service Agreement contract between [contracted dietary department] and the facility, dated 4/20/17, indicated they assumed responsibility over kitchen management on 4/20/17, but had not provided RD consultation.

Review of the 4/15/18, Weight Policy/Supplement Procedure of Colonial Manor indicated:
(1) All new admissions will be evaluated by the CDM/DM with a call or fax to the MD as needed. No mention of the RD assessing any resident upon admission was made.
(2) After 7 days, weekly weights will begin unless ordered by the MD.

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F 801	Continued From page 17 (3) Weekly weights are taken by nursing staff and the CDM/DM or RN/LPN will review the weight sheets or EMR. There was no mention of the RD reviewing any residents' weights. (4)The CDM/DM will print out report and evaluate for significant weight gains or losses. The reports were to be brought to the IDT each week. There was mention of the RD being a part of the IDT team or that she would appropriately or actively assess concerns. (5) If weight loss was confirmed, and the resident is eating and drinking greater than 50%, the CDM/DM will monitor for another week before starting interventions. There was no mention of contacting the physician with this critical information or having RD-A assess the resident with deemed weight loss to prevent further loss. (6) If the resident was eating or drinking less than 50%, the MD was finally to be notified and the RD to be contacted and asked for recommendations. There was no mention of RD-A coming to the facility to make a nutritional assessment on a resident with confirmed weight loss. Interview on 5/31/18 with the medical director (MD)-A indicated he was not aware the survey team had entered the facility to ensure compliance with the plan of correction. He was unaware RD-A was not coming to the facility to make appropriate assessments for residents with identified nutritional concerns, or to assess newly admitted residents, or to assess residents with a significant change. He agreed it was a concern for repeated weight loss and continued deficient practice. MD-A's expectation was RD-A was to abide by her contract, and make recommendations based on an accurate assessment.	F 801		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OQWO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00302

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/06/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Dobie, HFE - NE II 05/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/10/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00322
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2018

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

RE: Project Number S5572028

Dear Ms. Goette:

On April 6, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 25, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective June 25, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 25, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June25, 2018.

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June25, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs
from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 June 25, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 6, 2018 (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
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: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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COLONIAL MANOR NURSING HOME	403 COLONIAL AVENUE LAKEFIELD, MN 56150

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/2 through 4/6/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A standard survey was completed at your facility by the Minnesota Department of Health from On 4/2 through 4/6/18, to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		4/6/18

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

Electronically Signed | 05/03/2018

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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control measures were implemented in a dignified manner for 1 of 1 resident (R5) who was	F 550	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	

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F 550	Continued From page 2 reviewed for contact isolation precautions related to a urinary tract infection. Findings include: During observation on 4/3/18, at 12:46 p.m. R5 was observed sitting in his wheelchair with a covered urinary bag attached to wheelchair. Signage was observed outside R5's doorway: see nurse prior to entering-contact precaution. Nursing assistant (NA)-B stated R5 was on contact precautions and isolated to his room with a urine infection. Review of Sanford Health hospital interagency transfer orders dated 3/28/18, identified R5 had a urinary tract infection (UTI) due to extended-spectrum beta lactamase (ESBL) producing Escherichia coli (a bacteria that is not easily treated with common antibiotics). R5's Quarterly Minimum Data Set (MDS) assessment dated 3/23/18, identified R5 as cognitively intact. The MDS further identified R5 as being frequently incontinent of bladder and needing extensive assistance for toileting and transfers. R5's care plan, revised 3/28/18, identified R5 had a UTI with ESBL. Interventions included contact precautions to be followed by staff. During interview on 4/6/18, at 8:21 a.m. R5 stated, "Why am I quarantined"? R5 indicated staff had not allowed him to leave his room since coming back from the hospital. R5 stated he would like to go to the dining room for meals, sit with his table mates, and was sad he could not leave his room to be with other people.	F 550	admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. It is the policy of this facility to ensure that the least restrictive measures are taken for residents on isolation precautions. The infection control isolation procedure was modified to ensure that isolation precautions will be reviewed on a daily basis and as needed by licensed nursing staff and/or IDT while precautions are in place to ensure that the least restrictive measures are being utilized to promote resident dignity. Corrective action for the affected resident was completed on 4/6/2018, and facility ensured that the least restrictive measures were being utilized. On 4/27/2018, the facility also put into place a dignified services policy to address accommodation of resident needs and preferences. An all-staff meeting was held on 5/1/2018 to educate all staff on policy changes. Any future residents that have the potential to be affected will be reviewed according to the revised policy. The revisions to the policy will ensure that future residents will not be adversely affected. The facility will further review and monitor isolation precautions at QA meetings.	

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F 550	Continued From page 3	F 550		

During interview on 4/6/18, at 8:21 a.m., registered nurse (RN)-B stated R5 was isolated to his room related to ESBL in his urine. RN-B confirmed urine was contained in a closed urinary drainage system placed 3/31/18, with no knowledge of any leakage. RN-B stated the facility followed the "Minnesota Board of Health directions," for infections and infection control precautions, however, did not identify any specific written infection control standards which would require R5 to be isolated to his room.

During interview on 4/6/18, at 8:50 a.m., NA-B stated, R5 was a "very social person" and liked to come out for coffee, activities and bingo. NA-B further stated R5 can not leave his room because of an infection.

During interview on 4/06/18 9:04 a.m., NA-H stated R5 is not allowed to come out of his room R5 has an UTI and is on special precautions.

When interviewed on 4/6/18, at 9:06 a.m., RN-A indicated it was important to R5 to eat meals in the dinning room, but the facility was unable to allow this while R5 was on contact precautions. RN-A further confirmed the urine was contained in a closed urinary drainage system, and stated there was a potential the urine drainage bag could break.

When interviewed on 4/6/18, at 9:16 a.m. the director of nursing (DON) stated residents on contact precautions were isolated to their room during treatment or active symptoms. The DON further indicated the facility followed the same guidelines used at the hospital and re-iterated keeping R5 isolated to his room was appropriate,

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F 550	Continued From page 4 however, did not provide any specific written infection control standards. During phone interview on 4/06/18, at 10:25 a.m. the nurse practitioner healthcare (NPH), stated if ESBL in the urine was contained in a urine drainage bag, a resident would not need to be isolated to their room. A facility policy titled Infection Control-Isolation Procedure/Outbreak control revised 1/2017, indicated the facility shall ensure the least restrictive measure is taken when utilizing infection control methods. A facility policy was requested related to dignified services, none was provided.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure access to the call light for 1 of 2 residents (R24) that were reviewed for reasonable accommodation of needs. Findings include: R24's care plan dated 2/9/18 indicated to keep the call light within reach when in room	F 558	All staff were educated regarding call light placement with residents' reach when residents are in their rooms. Call light audits were initiated on 4/4/2018. On 4/9/2018, R24 was given an additional call light to utilize when out of bed, since R24 is independent with bed mobility and transfers. R24's care plan was reviewed and revised to reflect resident needs and preferences. R24 prefers to have call light	4/9/18

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F 558	Continued From page 5 unattended. R24's face sheet dated 12/24/17 revealed a diagnosis of: breast cancer, liver cancer and osteoporosis. During a observation and interview on 4/2/18, at 1:39 p.m., R24 was sitting in a wheelchair in her room. The call light was tied on the bed rail on the back side, against the wall. R24 stated that the call light was unreachable, and stated that she had spoken with the staff about this before. R24 stated that she preferred the call light on the back rail of her bed when she is sleeping, however, stated the staff would forget to relocate the call light when she got out of bed. During observation and interview on 4/5/18, at 5:02 p.m., R24's call light was observed to be tied to the back rail on the back side of the bed positioned against the wall. Nursing assistant (NA-A) was called to R24's room. NA-A confirmed R24 not reach the call light, and then fastened the call light to the front of the bed where R24 could reach it. During observation and interview on 4/6/18, at 9:11 a.m., R24's call light was found attached to the rail on the back side of the bed, next to the wall. R24 could not reach the call light. NA-G was called to the room, and verified R24 could not reach the call light. NA-G put the call light within reach of the resident and fastened it to the bed linen on the front side of the bed. R24 thanked NA-G. On 4/6/18, at 10:02 a.m., the director of nursing (DON) was notified that the call light could not be accessed several times during the survey. The	F 558	on grab bar next to wall when in bed. To ensure that R24 is able to access call light when out of bed, the additional call light was placed in a location that R24 can access when out of bed, so staff do not need to move call light location, and resident can continue to be independent in room. Audits were initiated to ensure that all other residents that potentially may be affected will have call lights within reach when they are in their rooms. Random audits will be completed multiple times per week at varied times for 1 month by DON or designee to ensure that call lights are within reach for all residents. Then, random audits will continue to be performed for 3 months with results reported at QA meetings.	

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F 558	Continued From page 6 DON revealed that staff had been reminded to leave call lights in place where the residents could reach them. A policy was requested for accommodation of resident needs related to call light placement, and none was provided.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		4/13/18

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F 584	Continued From page 7 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bathrooms were maintained in a clean manner for 5 of 35 resident rooms (Room #1, #7, #9 & #13) observed. Findings include: On 4/2/18 at 10:45 a.m., thes bathroom vent in Room #9 was observed to have thick, gray dust and dirt, collected on the fan, and the vent cover. On 4/2/18 at 11:33a.m., the bathroom vent in Room #1 was observed to have loose, thick, gray dust and dirt, 1/4 to 1/2 inch thick covering the entire metal of the vent. On 4/3/18 at 1:10 p.m., the bathroom vent in Room #7 was observed to have thick gray dust and dirt. On 4/5/18 at 1:50 p.m., the bathroom vent in Room #13 was noted to have thick gray dust and dirt, 1/4 to 1/2 inch thick covering the entire metal of the vent. On 4/6/18 at 9:40a.m., a tour was completed with	F 584	Corrective action for those residents found to have been affected was by cleaning the resident bathroom vents on 4/6/2018 by housekeeping. To identify other residents having the potential to be affected by the same deficient practice - all resident bathroom vents were inspected and cleaned by housekeeping on 4/6/2018. To ensure that the deficient practice will not recur, a housekeeping schedule was revised to include weekly cleaning of the resident bathroom vents that includes the housekeeper initialing off the task each week when completed. To monitor that the solution is effective the Housekeeping Department Supervisor will review that the housekeepers are completing the task weekly by doing a weekly bathroom vent inspection for cleanliness and random spot checks will be completed by the Director of Maintenance or other designated person.	

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F 584	Continued From page 8 the maintenance director. The maintenance director confirmed the above findings during the tour. In addition, a schedule was requested for cleaning, and none was provided.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 609	An all-staff meeting was held on 5/1/2018	5/1/18

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F 609	Continued From page 9 facility failed to report allegations of abuse to the State agency (SA) in a timely manner for 3 of 4 residents (R1, R3 & R19) whose incidents were reviewed. Findings include: R3's quarterly Minimum Data Set (MDS) assessment dated 12/22/17, included a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS further indicated R3 required extensive assist with bed mobility, transfer, locomotion on/off unit, dressing, eating, toileting, and personal hygiene. The quarterly MDS also indicated R3 denied pain, was not on a scheduled pain medication regimen, and had not received any as needed pain medications during the look back period. A 12/25/17, Resident Incident Report completed by licensed practical nurse (LPN)-A at 6:00 a.m., indicated there was an unknown incident leading to R3 complaining of right leg pain, with a bruise observed on the right shin measuring 7 centimeters (cm) x (by) 3 1/2 cm which was blue in color. The report indicated R3 had been unable to explain the injury. According to the report, immediate interventions implemented included use of a full body lift due to pain in right lower extremity, APAP (acetaminophen) given and ice applied. The report further indicated the on-call physician was notified of the resident's injury by telephone at 11:45 a.m. on 12/25/17, the family was notified at 11:50 a.m. on 12/25/17, the administrator was notified on 12/25/17, at 12:05 p.m. and the DON (director of nursing) was notified 12/25/17, at 12:25 p.m.. The incident report further indicated a VA (vulnerable adult) report was submitted to the State Agency at 12:39	F 609	to educate staff on guidelines for reporting of incidents and vulnerable adult report filing to OHFC. Education was provided on timely reporting of incidents and VA reports. Incidents which are defined as injuries of unknown source must be reported per guidelines. Incident Reporting policy was revised on 4/9/2018 to include the tracking ID number for any VA reports filed to ensure that submissions are completed and accepted in a timely manner. In order to prevent other residents from being affected, VA reports will be filed according to the guidelines, and policy was modified to further specify the procedure. The Director of Social Services/designee will audit incident reports that have been filed as VA reports for 3 months to ensure timeliness of reporting. Results will be reviewed at QA meetings.	

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F 609	Continued From page 10	F 609		

p.m. on 1/3/18.

When interviewed on 4/5/18, at 1:38 p.m. the DON stated everyone who had worked on 12/24/17 and 12/25/17 as well as R3's family were interviewed. DON further stated that the cause of the injury was not found and no specific incident to relate it to was noted. DON further stated she reasonably assumed it happened when R3's children and grandchildren were visiting the day prior to R3 having pain and bruising. DON verified no further investigation was completed related to the pain and bruising to R3.

When interviewed on 4/10/18, at 11:20 a.m. medical doctor (MD)-B, who'd been on call for R3's primary physician at the time of the injury, stated during R3's hospitalization 1/3/18, there had also been a small brain bleed diagnosed. MD-B said "the brain bleed, combined with the spiral-like fracture, indicates there must have been an unwitnessed fall to result in that extensive of injury." MD-B verified having received notifications R3 had pain, but was unable to recall exact details.

R1's quarterly Minimum Data Set (MDS) dated 12/15/17, indicated R1 had diagnoses of Alzheimers, dementia, seizure disorder, aphasia, anxiety, delusional disorder, and major depressive disorder. The MDS also indicated that R1 needed extensive assist with all activities of daily living and the corresponding brief interview for mental status (BIMS) indicated R1 had severely impaired cognition.

Review of R1's Resident Incident Report dated 1/6/18, at 6:20 a.m. indicated a bruise noted at

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F 609	Continued From page 11	F 609		

6:20 a.m. located in the middle of the forehead, blue/purple in color, 5 centimeters (cm) x (by) 4 cm. Noted bruise raised more by 7:30 a.m. and measured 7 cm x 5 cm. The report further indicated R1 was unable to state how the injury occurred but staff could explain how it occurred. The cause of bruise was not determined in the incident report investigation. Investigative note dated 1/6/18, at 11:00 p.m. indicated licensed practical nurse (LPN-B) stated, a little after 5:00 a.m. on 1/6/18, a noise was heard that sounded like an argument between R1 and R1's roommate; LPN-B was cleaning up R1's bathroom at that time. Upon exiting the bathroom, LPN-B visualized R1 sitting on roommate's bed and roommate was sitting up in bed. LPN-B indicated he had not observed any physical altercation between the two residents. Bruising to R1's forehead was noted one hour and 20 minutes later.

Nursing progress note dated 1/8/18, at 8:20 p.m. indicated R1's husband informed nurse of bruising to R1's three fingers of her left hand. Nurse noted that there was dark blue bruising on the last 3 fingers of R1's left hand. One nursing assistant (NA) [indicated NA's initials] who was interviewed stated the bruises were present the same day as the bruising was discovered on R1's forehead. Director of Nursing (DON) notified.

Telephone order received on 1/9/18, at 2:50 p.m. ordered x-ray of the right hand. According to nursing progress note dated 1/9/18, at 3:17 p.m. telephone clarification was received to apply ace wrap/brace during the day and ice hand for 5 minutes twice a day for 5 days.

X-ray results of right hand received on 1/9/17,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12	F 609		

indicated no acute fracture and no dislocation.

No investigation or incident report was completed for the bruising on R1's right hand. No report was filed to the State Agency (SA) regarding either the bruising to R1's forehead or significant bruising to R1's hand.

When interviewed on 4/5/18, at 1:51 p.m. about R1's bruise on forehead the DON stated, the bruise had been reported to her but further stated that the reporting nurse had told her R1 had bumped her head on the grab bar in the bathroom that she holds onto when transferring. After DON reviewed 1/6/18 incident report in the presence of the surveyor, she questioned the previous determination of the grab bar causing the bruise to the forehead. DON also confirmed the bruise was not reported to the state agency. DON further stated she did not report the bruising to the three fingers on the right hand that was noted on 1/8/18 because it was thought that the bruising was present and included on the original 1/6/18 occurrence and incident report. DON verified that no further investigation was done regarding the bruising to R1's right hand.
R19's Quarterly MDS, dated 2/2/2018, indicated current diagnoses of Alzheimer's disease, anxiety, and depression. The MDS further identified a Brief Interview for Mental Status score of 4 indicating severe cognitive impairment.

A Resident Incident Report dated 3/22/18, at 7:00 p.m. indicated R19 and R30 had a physical altercation resulting in no injury. R19 sat in a hallway by the facility time clock when R30 independently propelled over to R19 in a wheelchair and struck R19 on the right arm. R19 responded by striking R30 in return. R30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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F 609	Continued From page 13	F 609		

independently propelled away from R19 following the altercation. Both residents were separated from each other following the incident. Registered nurse (RN)-C contacted the director of nursing (DON) on 3/22/18 at 7:43 p.m., the administrator on 3/22/18, at 7:58 p.m., R19's daughter by phone on 3/23/18, at 9:32 a.m., and the physician by fax on 3/23/18, at 4:20 p.m. A twenty-four hour follow-up note on the Resident Incident Report dated 3/23/18, at 9:30 p.m. indicated the residents had not attempted to start any problems with each other after altercation. The facility interdisciplinary team reviewed the incident on 3/23/18, no further intervention was noted. The Resident Incident Report Indicated a Vulnerable Adult Report (VA) was submitted to the Minnesota Adult Abuse Reporting Center (MAARC) on 3/23/18, at 9:53 a.m.

On 4/04/18, at 2:30 p.m. the DON was interviewed about R19's incident report dated 3/22/18. DON stated RN-C was unable to log onto the MAARC website to submit the report on 3/22/18; RNC then contacted the DON to let her know of the inability to file the report. DON stated the report was submitted the next day on 3/23/18, because there were no injuries to either resident. DON stated when a nurse is unable to log in, either the on-call RN or DON are contacted to submit the report into MAARC. The DON or on-call RN would be expected to come in to submit a report if it was needed sooner than 24 hours. Only full-time and part-time nurses are allowed access to the MAARC reporting system; nurses who are casual are not permitted access. RN-C had just changed her status to full time, and was having problems setting up her access password. DON stated issues with this happened for about six months after the reporting system

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	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 609	Continued From page 14	F 609		

changed.
When interviewed on 4/4/18, at 2:44 p.m. RN-C indicated being unable to submit R19's incident report on line as was unable to log into the MAARC website. RN-C stated an error message repeatedly appeared at the login page otherwise the report would have been submitted immediately had the site been accessible. RN-C stated the process to submit an incident report if a nurse cannot log into MAARC is to contact the DON to submit the report. RN-C was not able to log into the reporting site since her work status changed from casual to full time about two weeks ago.
On 04/05/18, at 2:01 p.m. an interview with RN-A indicated the DON and Administrator are notified of all incidents to determine the need to submit a VA report. All nurses have been trained and are able to make VA reports. RN-A recalled a time on 3/31/18, when she was on call. RN-C could not submit a report so RN-A came to the facility to submit the report as RN-C was aware of the requirements for timely reporting.
The facility policy entitled Abuse Prevention Plan, dated 10/31/16, included the facility requires that all suspected maltreatment will be reported to the Common Entry Point (CEP) and online to the Office of Health Facility Complaints (OHFC). All staff are required to report suspected maltreatment of a vulnerable adult to the Director of Nursing (DON), Administrator of the charge nurse in accordance with the policy and procedure. The policy further defines reporting of injuries of unknown source to occur when the source of injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicion because of the extent of the injury or the location of the injury (e.g., the injury is located in an area

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	245572	A. BUILDING _____ B. WING _____	04/06/2018

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F 609	Continued From page 15 not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidents of injuries over time. The policy continues to stated that all alleged incidents of maltreatment are reported immediately to the state agency and to all other agencies as required and all necessary corrective actions, depending on the result of the investigation are taken. "Immediately" means as soon as possible.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assure the injuries of unknown source were thoroughly investigated for 2 of 2 residents (R1 & R3) reviewed for abuse. Findings include:	F 610	An all-staff meeting was held on 5/1/2018 to educate staff on incident report investigations. Incident report policy was revised 4/9/2018 to ensure that all incidents are thoroughly investigated. DON/designee will review for	5/1/18

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	245572	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 16 R1's quarterly Minimum Data Set (MDS) dated 12/15/17, indicated R1 had diagnoses of Alzheimers, dementia, seizure disorder, aphasia, anxiety, delusional disorder, and major depressive disorder. The MDS also indicated that R1 needed extensive assist with all activities of daily living and the corresponding brief interview for mental status (BIMS) indicated R1 had severely impaired cognition. Review of the Resident Incident Report dated 1/6/18, at 6:20 a.m. indicated a bruise noted at 6:20 a.m. located in the middle of the forehead, blue/purple in color, 5 centimeters (cm) x (by) 4 cm. Noted bruise raised more by 7:30 a.m. and measured 7 cm x 5 cm. The report further indicated R1 was unable to state how the injury occurred but staff could explain how it occurred. The cause of bruise was not determined in the incident report investigation. Investigative note dated 1/6/18, at 11:00 p.m. indicated licensed practical nurse (LPN-B) stated, a little after 5:00 a.m. on 1/6/18, a noise was heard that sounded like an argument between R1 and R1's roommate; LPN-B was cleaning up R1's bathroom at that time. Upon exiting the bathroom, LPN-B visualized R1 sitting on roommate's bed and roommate was sitting up in bed. LPN-B indicated he had not observed any physical altercation between the two residents. Bruising to R1's forehead was noted one hour and 20 minutes later. Nursing progress note dated 1/8/18, at 8:20 p.m. indicated R1's husband informed nurse of bruising to R1's three fingers of her left hand. Nurse noted that there was dark blue bruising on the last 3 fingers of R1's left hand. One nursing	F 610	documentation of thorough investigation when assessing incident reports for completeness. Education will continue to be provided to staff on an as needed basis to ensure thorough investigations are completed for each incident report. DON/designee reviews each incident report once completed, and results will be reviewed at QA meetings for 6 months.	

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	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 610	Continued From page 17	F 610		

assistant (NA) [NA's initials] who was interviewed stated the bruises were present the same day as the bruising was discovered on R1's forehead. Director of Nursing (DON) notified.

A telephone order received on 1/9/18, at 2:50 p.m. ordered x-ray of the right hand. According to nursing progress note dated 1/9/18, at 3:17 p.m. telephone clarification was received to apply ace wrap/brace during the day and ice hand for 5 minutes twice a day for 5 days.

X-ray results of right hand received on 1/9/17, indicated no acute fracture and no dislocation.

No investigation or incident report was completed for the bruising on R1's right hand. No report was filed to the State Agency (SA) regarding either the bruising to R1's forehead or significant bruising to R1's hand.

When interviewed on 4/5/18, at 1:51 p.m. about R1's bruise on forehead the DON stated, the bruise had been reported to her but further stated that the reporting nurse had told her R1 had bumped her head on the grab bar in the bathroom that she holds onto when transferring. After DON reviewed the 1/6/18 incident report in the presence of the surveyor, she questioned the previous determination of the grab bar causing the bruise to the forehead. DON also confirmed the bruise was not reported to the state agency. DON further stated she did not report the bruising to the three fingers on the right hand that was noted on 1/8/18 because it was thought that the bruising was present and included on the original 1/6/18 occurrence and incident report. DON verified that no further investigation was done regarding the bruising to R1's right hand.

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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

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F 610	Continued From page 18	F 610		

R3's quarterly Minimum Data Set (MDS) assessment dated 12/22/17, included a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS further indicated R3 required extensive assist with bed mobility, transfer, locomotion on/off unit, dressing, eating, toileting, and personal hygiene. The quarterly MDS also indicated R3 denied pain, was not on a scheduled pain medication regimen, and had not received any as needed pain medications during the look back period.

A 12/25/17, Resident Incident Report completed by licensed practical nurse (LPN)-A at 6:00 a.m., indicated there was an unknown incident leading to R3 complaining of right leg pain, with a bruise observed on the right shin measuring 7 centimeters (cm) x (by) 3 1/2 cm which was blue in color. The report indicated R3 had been unable to explain the injury. According to the report, immediate interventions implemented included use of a full body lift due to pain in right lower extremity, APAP (acetaminophen) given and ice applied. The report further indicated the on-call physician was notified of the resident's injury by telephone at 11:45 a.m. on 12/25/17, the family was notified at 11:50 a.m. on 12/25/17, the administrator was notified on 12/25/17, at 12:05 p.m. and the DON (director of nursing) was notified 12/25/17, at 12:25 p.m.. The incident report further indicated a VA (vulnerable adult) report was submitted to the State Agency at 12:39 p.m. on 1/3/18.

When interviewed on 4/5/18, at 1:38 p.m. the DON stated everyone who had worked on 12/24/17 and 12/25/17 as well as R3's family were interviewed. DON further stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 610	Continued From page 19	F 610		

cause of the injury was not found and no specific incident to relate it to was noted. DON further stated she reasonably assumed it happened when R3's children and grandchildren were visiting the day prior to R3 having pain and bruising. DON verified no further investigation was completed related to the pain and bruising to R3.

When interviewed on 4/4/18, at 2:44 p.m. RN-C indicated being unable to submit R19's incident report on line as was unable to log into the MAARC website. RN-C stated an error message repeatedly appeared at the login page otherwise the report would have been submitted immediately had the site been accessible. RN-C stated the process to submit an incident report if a nurse cannot log into MAARC is to contact the DON to submit the report. RN-C was not able to log into the reporting site since her work status changed from casual to full time about two weeks ago.

The facility policy Incident Reporting-Resident, dated May 2017, stated that a "Resident Incident Report" is completely filled out on all "incidents" (an incident is defined as injury to a resident and/or anything out of the ordinary or unusual happening, i.e.: skin tear, fall (witnessed/unwitnessed), altercation between residents, resident elopement, etc.). The policy further indicates immediately upon discovery of an incident, a licensed employee with knowledge of the incident completes the first page of the Resident Incident Report and a licensed nurse must complete the 24 hour follow up. The policy further states that incidents are reviewed by the interdisciplinary team (IDT) at morning stand up meeting.

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	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 610	Continued From page 20 The facility policy entitled Abuse Prevention Plan, dated 10/31/16, The facility policy entitled Abuse Prevention Plan, dated 10/31/16, included the facility requires that all suspected maltreatment will be reported to the Common Entry Point (CEP) and online to the Office of Health Facility Complaints (OHFC). All staff are required to report suspected maltreatment of a vulnerable adult to the Director of Nursing (DON), Administrator of the charge nurse in accordance with the policy and procedure. The policy further defines reporting of injuries of unknown source to occur when the source of injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicion because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidents of injuries over time. The policy continues to stated that all alleged incidents of maltreatment are reported immediately to the state agency and to all other agencies as required and all necessary corrective actions, depending on the result of the investigation are taken. "Immediately" means as soon as possible. Additionally, included the Director of Nursing (DON) and/or Administrator ensures that the internal investigation begins immediately, ensures that the appropriate reporting takes place and that interventions are implemented to provide the vulnerable adult with a safe living environment. This policy further states that incidents are reported, documented, and investigated internally using the Colonial Manor Incident Reporting policy and procedure.	F 610		
F 684	Quality of Care	F 684		5/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 684 SS=G	Continued From page 21 CFR(s): 483.25 § 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 interview and document review, the facility failed to ensure prompt medical care and treatment was obtained for 1 of 2 residents (R3) reviewed for hospitalization. R3 sustained actual harm, prolonged discomfort, due to delayed nursing assessment and medical care for a right tibia/fibula spiral fracture. Findings include: R3's quarterly Minimum Data Set (MDS) assessment dated 12/22/17, included a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS further indicated R3 required extensive assist with bed mobility, transfer, locomotion on/off unit, dressing, eating, toileting, and personal hygiene. The quarterly MDS also indicated R3 denied pain, was not on a scheduled pain medication regimen, and had not received any as needed pain medications during the look back period. R3's care plan last revised 3/29/18, indicated R3 required assist of 2 with full body lift as of 12/25/17. Prior to 12/25/17, the care plan had indicated R3 required extensive assist of 2 staff	F 684	An all-staff meeting was held on 5/1/2018 to educate staff on obtaining prompt medical care related to resident needs. Incident report policy has been modified to reflect changes. If resident's condition has worsened or resident has not made an improvement in medical condition related to the incident, physician must be contacted again to advise further medical treatment. Nursing to continue to monitor resident's condition to observe for signs/symptoms of worsening condition or indications of condition not showing improvement. Monitoring of falls and incidents with injury will be conducted at least every shift for 72 hours, and monitoring may continue longer if warranted. All residents have the potential to be affected. DON will audit incident reports, incident investigations, and resident medical record to ensure compliance. Results will be reviewed and discussed at QA meetings for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 684	Continued From page 22	F 684		

with use of stand aid for transfers and did not walk due to hemiparesis.

A nursing progress note dated 12/24/17, at 11:58 p.m. (recorded as late entry on 12/29/7 at 12:23 a.m.) indicated: "When doing routine nursing tasks at 2230 (10:30 p.m.), writer noted that resident was taking [sic] repeatedly, 'Oh boy, Oh boy,' when asked what was wrong resident was not able to address issues. Per previous encounter writer was aware of residents' behaviors that she could get louder and talk repeatedly in two cases most of the time. She is either thirsty or wet. offered [sic]resident water to drink and resident took couple sips, writer left the room. Kept an eye on resident, resident was still awake at 2300 chanting 'Oh boy, Oh boy'." The progress note also indicated at that time, the writer had checked R3 for incontinence and the resident was slightly wet. The note indicated during the provision of care, as the staff attempted to "roll away resident [to change], resident got louder and complained of pain at right leg. Assessed resident lower extremities and noted a little reddened area but no bruise at the time. Resident was unaware of what have [sic] happened to her leg but still c/o (complained of) pain with touch or movement. Offered Tylenol but resident refused. When day shift arrived it was reported that bruises were forming in lower right leg. Assessed resident with day nurse and an incident report was filed..."

A 12/25/17, Resident Incident Report completed by licensed practical nurse (LPN)-A at 6:00 a.m., indicated there was an unknown incident leading to R3 complaining of right leg pain, with a bruise observed on the right shin measuring 7 centimeters (cm) x (by) 3 1/2 cm which was blue

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) COMPLETION DATE
F 684	Continued From page 23	F 684		

in color. The report indicated R3 had been unable to explain the injury. According to the report, immediate interventions implemented included use of a full body lift due to pain in right lower extremity, APAP (acetaminophen) given and ice applied. The report further indicated the on-call physician was notified of the resident's injury by telephone at 11:45 a.m. on 12/25/17, the family was notified at 11:50 a.m. on 12/25/17, the administrator was notified on 12/25/17, at 12:05 p.m. and the DON (director of nursing) was notified 12/25/17, at 12:25 p.m.. The incident report further indicated a VA (vulnerable adult) report was submitted to the State Agency at 12:39 p.m. on 1/3/18.

Further review of R3's nursing progress notes indicated:

- 12/25/17, 11:53 a.m. documented by LPN-A, Resident had bruise noted on right shin @ (at) 6 am. Area 7 cm long and 3 1/2 cm wide and blue in color. Right lower extremity warm and swollen with extreme pain noted with movement. On Call MD (medical doctor) called and was informed of resident's pain in right leg. LPN-A had requested an order to transfer R3 by ambulance to the ER (emergency room) for evaluation. The physician had given an order for Tramadol 50 mg (milligrams) by mouth every 4-6 hours for severe pain, and for use of Tylenol 650 mg every three hours after Tramadol. The note indicated the physician had wanted to attempt medication use before R3 being seen in ER. The note also indicated R3's family was at the facility and had been notified of the bruising, pain and use of the pain medications. LPN-A had checked R3's right leg with the family present. The resident had denied pain in the knee, back of lower leg, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24	F 684		

foot, but had acknowledged pain on the right shin area.

-12/25/17, at 12:41 p.m. LPN-A documented R3 was laying in bed visiting family with ice applied to right lower extremity. LPN-A had also documented R3 complained of pain in the lower right extremity, but had denied right hip, knee and upper extremity pain. The note also indicated R3 had received an as needed (PRN) Tramadol at 12:20 pm.

-12/25/17, at 5:12 p.m. progress note indicated that during supper on 12/24/17, the cook brought R3 out of the dining room prior to completion of the meal. The note indicated R3 informed the cook she needed to use the bathroom. The cook reported the resident was not exhibiting any behavioral symptoms and included, "Writer spoke with resident at the NS (nurses station). Asked resident if she needed to use the restroom and resident shook her head no. Writer noticed that resident appeared to have a new pair of velcro shoes on and the right one had its velcro loosened considerably. When asked if she was experiencing any pain or discomfort, resident looked down towards that shoe. Writer offered to remove the shoe as it appeared to be causing her some discomfort, but resident refused. Resident also refused to go back into the dining room, but did agree to go to her room. After reaching the room, writer again offered to remove the shoes and resident again refused and was smiling. Later in the shift after this writer had completed cares with resident's roommate, noticed resident was still awake. Asked if she wanted to keep the TV on to which she said, "Yes, TV". Resident again offered no complaints of pain or discomfort."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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F 684	Continued From page 25	F 684		

-12/25/17, at 5:23 p.m. a nursing progress note included, "This afternoon at approximately 1600 (4:00 p.m.), writer was walking by resident's room and noticed she was awake. Entered the room and asked resident if she was aware what had happened to her leg. She stated, 'I don't know.' When asked if she was experiencing any pain or discomfort, responded, 'some.' Declined offer of pain medication at that time."

-12/25/17, at 9:05 p.m., a nursing progress note indicated when R3 had been asked prior to supper whether she had hit her leg, the resident "responded 'yes', but was unable to recall what it was."

A fax (facsimile) communication to R3's physician dated 12/26/18, included, "bruise noted to lower right shin measuring 7 x 3.5 cm - complaining of pain, extreme at times with movement, Tramadol ordered with Tylenol with ice, will continue to monitor, nurse requested an order to continue current interventions and 'please advise if any further direction'." R3's physician had confirmed the current interventions and signed the fax.

A nursing progress note dated 12/27/17 9:42 p.m. included: "Fax back with YES to request for Tramadol, take 1 tablet (50 milligram (mg)) orally 3 times a day and every 4 hours PRN. [family member's name] informed."

A nursing progress note dated 12/28/17, at 1:17 p.m. by LPN-A included, "Resident c/o pain pain with movement in right leg. Tramadol helps with pain control but resident still expresses pain in right leg. Right leg swollen and warm to touch. No redness noted."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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 684	Continued From page 26	F 684		

No documentation was present in R3's progress for 12/29/17, 12/30/17, or 12/31/17.

A nursing progress note dated 1/1/18, at 3:59 p.m. indicated R3 continued to have "severe in right lower leg pain, and screamed and cried with pain when it was moved forward. The right lower leg continued to be black and blue and swollen. Call placed to [family member name] and he is agreeable to having a portable X ray done. Message left on [family member's name] phone and fax to Dr. [physician's last name]."

A faxed physician's communication, dated 1/1/18, at 5:23 p.m. indicated R3's leg had been injured 12/24/17, but it was unknown how. "Right lower leg area is black, blue, swollen, and she screams and cries with movement. Family does not want to take her [to the hospital] but would agree to a portable x-ray. Request for a portable x-ray." Physician response included an order for "x-ray of right tibula/fibula" which had been received by the facility on 1/2/18.

A nursing progress note dated 1/2/18, at 4:03 p.m. included: "[family member's name] notified of x-ray will be done tomorrow due to inability to do it today."

A portable x-ray of R3's right lower right extremity was completed on 1/3/18, at 10:45 a.m., which showed a spiral fracture of the mid to distal tibial shaft that appears acute/traumatic with about 7 degrees anterior angulation and spiral comminuted fracture of the fibula noted. X-ray results were faxed to [physician's name] for review at 11:10 a.m. A nursing progress note dated 1/3/18, at 1:25 p.m. written by the director of nursing (DON) indicated that a telephone order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

had been received for resident to be transferred to the emergency room for further evaluation. R3's nursing progress note dated 1/4/18, at 2:39 p.m. indicated R3 was admitted to the hospital for surgical repair but due to a small brain bleed, surgery was not done and comfort measures ordered.

A nursing progress note, dated 1/5/18, at 2:51 p.m. indicated R3 returned from the hospital on 1/5/18, at 2:15 p.m. with the diagnosis of right spiral fracture to tibia and fibula without surgical intervention. The progress note further indicated R3 returned with a soft cast with ace wrap to right lower leg that was to be kept in place until follow up visit with the orthopedic physician on 2/16/18.

When interviewed on 4/4/18, at 3:34 p.m. nursing assistant (NA)-A, confirmed R3 had pain in her right leg prior to hospitalization on 1/3/18. NA-A stated it had started with R3 wanting to have her right shoe taken off of her foot. NA-A stated he'd told the nurse it seemed like something was bothering R3's right leg and foot. NA-A said R3's right leg had started to swell and she was hospitalized, but verified not knowing what had happened to the leg. NA-A stated during the time when R3 had been injured, R3 had propelled herself about in her wheelchair and may have run into something. NA-A stated that prior to hospitalization the resident was transferred with a standing lift, then upon return from the hospital utilized a Hoyer (mechanical full body) lift.

When interviewed on 4/5/18, at 7:22 a.m. registered nurse (RN)-A stated R3 complained of pain in the right leg but had just gotten new shoes and RN-A thought the shoes were causing the pain. R3 denied pain at first, but then started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 28	F 684		

to complain of pain and would want her shoes off. RN-A indicated the pain was "hit and miss," and monitored pain after the initial physician notification on 12/25/17. RN-A further stated R3 had increasing pain and swelling, and the facility had obtained an x-ray and found out it was fractured. R3 had a soft cast on the leg which was non-removable.

When interviewed on 4/5/18, at 1:08 p.m. NA-C verified being familiar with R3; however, hadn't been working during the time when R3's bruise and leg pain occurred. NA-C stated because R3 had a lot of pain, the Hoyer lift was initiated. NA-C said R3 had expressed pain when she was transferred, when moved, or even when she sat up. NA-C further stated the Tramadol and Tylenol had worked some of the time, but said R3 would yell and cry, "We have never seen her like that." NA-C was unsure what had happened to cause the injury to R3 and didn't think the reason for R3's leg injury had ever been determined.

When interviewed on 4/5/18, at 1:21 p.m., NA-H stated that R3 had been complaining of pain for about three to four days prior to the bruising showing up. NA-H stated she'd reported to the charge nurse when R3 was crying out in pain. NA-H stated they'd started using the Hoyer lift when the bruise had showed up on R3's leg however, NA-H was unsure what had been done about the bruising. NA-H stated she didn't know what had happened to R3, but stated something must have happened to cause the injury.

When interviewed on 4/5/18, at 3:24 p.m. LPN-A stated R3 was in "excruciating pain" and verified there was no pain noted prior to identification of the bruising on R3's leg. LPN-A described R3 as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29	F 684		

pretty content unless wanting to go to bed then her demeanor changed. It (pain) was brought to LPN-A's attention by the NA's which revealed that R3 expressed pain and discomfort with cares, and even with the Tramadol would still have pain if moved or even touched. LPN-A had talked to the family about it (bruise) when they were here for the holidays but R3's whole affect changed when family was here and she didn't express pain to them. LPN-A further indicated if nursing thought a resident should be seen by a doctor, the doctor would often order a different intervention to try first. LPN-A stated, depending on severity of pain, we (nursing) should probably let the physician know within 24 hours if interventions were ineffective but not sure what the policy was for notification of the doctor.

When interviewed on 4/5/18, at 5:16 p.m. NA-D and NA-E stated they had worked around the holidays when R3 acquired the bruise to her right leg. NA-D and NA-E further indicated R3 had a lot of pain with movement and when her leg was touched. NA-D stated R3 was better if she was just sitting or lying in bed, and further stated R3 did not want to go out to meals or activities because when she got up it would hurt. NA-D and NA-E were unaware of how the resident obtained the bruising/fracture.

When interviewed on 4/6/18, at 9:12 a.m. NA-F confirmed she had worked the morning on 12/25/17, and further stated being the staff that initially found/identified the bruising to R3's right shin. NA-F reported the bruise to the night nurse who had stated that it (the bruise) wasn't present the hour prior. NA-F identified there was a huge bruise but didn't know how it couldn't have been there an hour prior. NA-F further stated, " It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 30	F 684		

makes me mad, we kept reporting the pain and they had contacted the doctor and they had got an order for Tramadol". NA-F stated that the Tramadol helped a little because R3 wasn't crying out as much but still crying out with movement and touch.

When interviewed on 4/5/18, at 1:38 p.m. the DON stated she'd been notified and was aware of R3's bruise and pain in her right lower extremity. The DON summarized the series of events to include that R3 had expressed pain during the night shift of 12/24/17, was still having pain the next day, the physician had been notified, Tramadol ordered, and R3's children had been informed. The DON stated R3's pain had been intermittent and nurses were visually monitoring the bruise and pain. The DON stated "after a few days they weren't satisfied just giving her pain medication resulting in another physician contact, x-ray, and hospitalization." The DON described her investigation into the bruising as including interviews with everyone who had worked on 12/24/17 and 12/25/17 but had not been able to determine what had happened to cause the bruising and pain. The DON further stated there wasn't an "incident" to link to the injury. The DON acknowledged the hospital summary note by the physician indicated there had been a fall involved, but stated there hadn't been a fall, because the resident would have not been able to get herself off the floor without assistance. The DON stated an x-ray had been requested on 1/1/18 (via fax), but had not been completed until 1/3/18, because the physician had not received the faxed request until 1/2/18. Further, the DON stated the portable x-ray company hadn't had staff available to do the x-ray 1/2/18, so it had waited another day to 1/3/18. Following the x-ray

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 31 completed on 1/3/18, a fracture had been diagnosed. The DON stated it was her expectation that any changes in a resident's condition would be documented in a progress note, and the doctor would be notified by phone. When asked why the doctor hadn't been called sooner when R3 was having prolonged pain, the DON stated she didn't know. When interviewed on 4/10/18, at 11:20 a.m. medical doctor (MD)-B, who'd been on call for R3's primary physician at the time of the injury, stated during R3's hospitalization 1/3/18, there had also been a small brain bleed diagnosed. MD-B said "the brain bleed, combined with the spiral-like fracture, indicates there must have been an unwitnessed fall to result in that extensive of injury." MD-B verified having received notifications R3 had pain, but was unable to recall exact details.	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 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;	F 692		5/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 32 §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 on observation, interview, and document review the facility failed to ensure interventions were implemented to address ongoing weight loss for 1 of 1 resident (R31) reviewed for nutrition. Findings include: R31's diagnoses report last updated 11/28/17 included: Parkinsons disease, dementia, abnormal weight loss, cardiac arrhythmia major depressive disorder, gastro-esophageal reflux disease, and osteoporosis. R31's care plan, updated 2/26/18, was not revised to address ongoing weight loss issues. The care plan did identify the resident was at risk for nutritional deficits related to Parkinsons disease, major depressive disorder, and had a history of abnormal weight loss and diverticulosis. Care plan approaches included: monitor and record intake of food and fluids, monitor weight weekly, provide extensive to total assist with eating and drinking meals. Also to provide extensive to total assistance with eating and drinking at meals, resident will at times feed self after set-up by staff. R31's monthly weight log identified a weight of 120 pounds in 9/3/17. The Minimum Data Set (MDS), dated 2/23/18, indicated R31 was	F 692	Corrective action was that the policy and procedure has been revised on 4/15/2018. Weights will be checked weekly. Weekly weight reports will be brought to the IDT each week. Reweights will be requested by DM or Licensed nurse if weight is +/- 3 pounds in 1 week. DM or Licensed Nurse will also request a reweigh if flagged by Matrix Care system when weight is entered. Progress notes will be charted by DM as needed or weekly on residents with significant weight loss. If weight loss is confirmed, MD will be notified and interventions will be put into place. Staff training was completed on 5/1/2018. CDM will complete random audits for 3 months to ensure compliance. Results will be discussed and reviewed at QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 33	F 692		

independent with eating and weighed 107 pounds, identifying a weight loss of 10% or more, not prescribed by a physician in the last six months.

The current physician order report signed by the provider, dated 2/6/18, included orders for a regular diet, and no specific interventions to address weight loss.

Review of physician progress notes from 4/19/17, to 12/7/17, revealed no physician assessment or interventions related to R17's continued weight loss.

Review of the nursing home medication and order review, signed by the doctor on 2/6/17 revealed, "I noted her weight is unchanged and averages between 112 and 114 pounds. I also noted that records indicate she eats 50-75% of meals."

A fax to the doctor dated, 3/13/18 revealed; resident has had some wt loss noted, her last quarterly assessment completed the end of February was noted to have 5% weight loss in 30 days and a 10% weight loss in 6 months. Did start resident on fortified foods and will continue to monitor. The fax was not responded to by the doctor, and there was no evidence of further follow up.

Document review of a form titled Care Conference summary, dated 3/1/2018, identified, dietary: current weight is 107#; eating 62% of meals and drinking 656 cc. at meals; diet - regular 5% weight loss in past month and almost 10% in 6 months.

Additional monthly weights on the weight log were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 34	F 692		

identified to be - 9/3/17 - 120 pounds (#); 10/3/17 -118#; 11/3/17-115#, 12/3/17-115#; 2/3/17-115#; 3/2/17 -110#; 3/7/17-111#; 3/16/17 - 111#; 3/21/17 - 108#; 3/28/17 - 102#; 4/4/17-104#.

During a observation on 4/4/18 at 9:18 a.m., R31 was extensively assisted by staff to eat, and consumed less then 25% of her meal.

During a interview on 4/04/18 10:06 a.m., the director of nursing (DON) stated weights are monitored weekly by the dietary manager and the MDS coordinator would address weight loss when completing the MDS.

During a interview on 4/5/18 10:32 a.m., nursing assistant (NA)-A revealed that he was responsible to help R31 with her meal, confirmed that R31 had been eating poor, and that her intake was worse in the last six weeks.

During a interview with the dietary director (DD) on 4/5/17 at 11:59 a.m., she revealed that a drop in weight was reviewed by nursing and dietary. She confirmed that there was not a dietary assessment completed since February, when R31 was started on a fortified diet. The dietary manager (DM) stated that R 31's weights will fluctuate week to week.

During interview on 4/6/18, at 9:07 a. m., the director of nursing (DON) confirmed dietary reviews weight loss weekly and evaluates the need for necessary interventions to prevent further weight loss. The DON stated the nutritional data sheet was filled out by the dietitian. The DON stated her expectation would be to revise the interventions due to continued weight loss since last dietary assessment 2/7/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 35 The DON further stated that when the nurse enters the weight it is captured on a screen in the software, the screen then needs to be changed to another setting to compare the weight with the history of weights. A copy of a policy regarding weight loss was requested and not provided.	F 692		

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	245572	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2018**

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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. At the time of this survey, Colonial Manor Nursing Home was found not to be 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2018

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

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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Colonial Manor Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1st Addition was constructed in 1979, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2nd Addition was constructed in 1999, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke	K 000		

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 37 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 37 out of 37 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25.	K 345	The Colonial Manor Fire Drill Report has been revised to include the statement "If silent alarm is utilized the fire alarm system **MUST** be tested within 12 hours prior to the actual fire drill being conducted" as a reminder to complete this step. Also, Colonial Manor has developed a new Fire Drill Yearly/Quarterly Schedule report form that includes Fire Alarm Activation Method. Both of these forms were completed on 4/20/2018 by the Director of Maintenance. The three deficiencies from the annual fire alarm inspection on 8/2/2017 (2 heat detectors and signal/horn) were corrected on 4/27/2018 by Simplex Grinnell.	4/27/18

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K 345	Continued From page 3 Findings include: On facility tour between 10:00 AM and 1:00 PM on 04/04/18, during documentation review, it was revealed that the DACT system was not tested after the 3rd shift fire drills during the 1st quarter, 2018 and the 2nd and 4th quarters in 2017 and the 3 deficiencies identified during the annual fire alarm inspection conducted on 08/02/2017 had not been corrected. This deficient practice was verified by the Facility Maintenance Director.	K 345	The Director of Maintenance is responsible for corrections of this deficiency and for monitoring in the future to prevent a reoccurrence of the deficiency.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		4/23/18

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K 351	Continued From page 4 by: Based on observation and interview, the Facility failed to ensure that spare fire sprinklers were kept in the sprinkler box at the sprinkler riser in accordance with NFPA 13. This deficient practice could affect 37 of the 37 residents. Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 04/04/2018, observation revealed, that there were two types of fire sprinkler heads within the same area in the Northwest Hallway and the Northwest Fireside Room. This deficient practice was verified by the Facility Maintenance Director.	K 351	On 4/23/2018 Building Sprinkler Inc. replaced sprinkler heads in the NW Hallway and Fireside room so all sprinkler heads matched. On 4/23/2018 Building Sprinkler, Inc. reviewed all spare sprinkler heads in the sprinkler head box at the riser to ensure we have adequate supply of spare heads that match all heads I the sprinkler box at the sprinkler riser. Director of Maintenance is responsible for the correction of this deficiency and for future monitoring to prevent a reoccurrence of the deficiency.	

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K 712 SS=E	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 documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 37 of 37 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. FINDINGS INCLUDE:	K 712	Colonial Manor has developed a new Fire Drill Yearly/Quarterly Schedule report form to ensure the fire drills are conducted at least quarterly on each shift, at expected and unexpected times under varying conditions. This form indicates date, time, alarm activation method, which shift and has a signature spot for the person initiating the drill. This form was completed on 4/20/2018 by the Director of Maintenance and reviewed by the Administrator. The Director of Maintenance is responsible for the correction of this deficiency and for future monitoring to prevent a reoccurrence of the deficiency.	4/20/18

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K 712	Continued From page 6 On facility tour between 10:00 AM and 1:00 PM on 04/04/2018, documentation review revealed that a 3rd shift fire drill was not conducted in the 1st quarter 2018 and the 2nd shift in the 3rd quarter 2017. This deficient practice was verified by the Facility Maintenance Director.	K 712		