Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 14, 2023

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

RE: CCN: 245572
Cycle Start Date: October 19, 2023

Dear Administrator:

On December 5, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 30, 2023

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

RE: CCN: 245572
Cycle Start Date: October 19, 2023

Dear Administrator:

On October 19, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by January 19, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 19, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. BUILDING _____ B. WING _____	C 10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/16/23 through 10/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/16/23 through 10/19/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55726463C (MN86257), H55726443C (MN96442), H55726496C (MN97801). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		12/1/23

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

Electronically Signed | 11/08/2023

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 689	Continued From page 1 §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 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 provide supervision for a 1 of 3 residents (R9) who was diagnosed with Alzheimer's disease and has a history of roaming and elopement. Findings include: R9's face sheet printed 10/19/23, included diagnoses of Alzheimer's disease (type of dementia that damages the brain, affects memory, thinking and behavior), psychosis (severe mental condition in which thought and emotions are so affected contact is lost with reality), and dementia (range of conditions that affects the brain's ability to think, remember and function normally). R9's quarterly Minimum Data Set (MDS) assessment dated 9/22/23, identified R9 had severely impaired cognition, unclear speech, sometimes understood, and sometimes understand others. The MDS identified R9 did not walk and used wheelchair for mobility. Further the MDS identified R9 required extensive assistance of one staff with eating and for locomotion. Behaviors included wandering occurred daily. Wandering impact was not answered. R9's elopement assessment last completed 9/22/23, identified exit seeking at times	F 689	This Plan of correction constitutes our written allegation of compliance for the deficiency cited. Colonial Manor's interdisciplinary team, in an attempt to manage R9 and other identified residents' ability to access others' table settings, seating placement and table setting procedures have been updated. Changes have been reviewed with the dietary staff on 11/8/2023 as to the seating placement of R9 and other residents in the dining room, along with a revised policy on table setting and clean up. In order to assure that R9 and other identified residents' risks of having the ability to access others' plate settings, Colonial Manor has reviewed and updated their care plans and educated staff to assure identified assistance is provided to R9 and other identified residents. Education was provided to all staff via email notification on 11/3/2023 of the need for everyone to be observing residents that tend to move about more in the dining room, to assure that residents are not attempting to access others' plate settings. Education provided included the risk this presents to a resident if they attempt to consume or touch another	

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F 689	Continued From page 2 secondary to dementia. R9 is able to self propel in wheelchair and has exhibited confusion, delusions, wandering, opening doors, and other risk factors. Needs frequent redirection but normally redirects well. R9 continues with Wanderguard at all times for safety of resident. R9's Care Area Assessment (CAA) dated 12/22/22, for dementia included R9 is unable to answer questions due to dementia. R9 is able to converse simply at times and other times will not respond. Conversation does not always make sense. Staff feel that resident's cognition is severely impaired. Resident does wander throughout the facility daily. Resident does have Alzheimer's. Staff to assist, give cues and redirect as able. R9's CAA for behaviors included R9 wanders throughout the facility and at times will open and close exit door without exiting building. Resident to continue to wear wanderguard. Continue to redirect as able. Resident does have diagnosis of Alzheimer's. R9's Plan of Care included an activities of daily living (ADL) plan of care dated 10/5/23, that included R9 requires assistance with ADL's related to Alzheimer's disease with severe cognitive deficits with increased anxiety and agitation in the evenings. R9 participates in eating by feeding self. Staff to provide setup and encouragement and cueing as needed during eating and drinking. R9 has been needing more assistance with eating and encouraging. R9's Plan of Care dated 10/4/23, included severe cognition impairment due to diagnosis of Alzheimer's. Interventions included approach resident slowly and from the front, give ample time to recall. Give resident cues and reminders	F 689	resident's plate setting. Dietary staff meeting was held on November 8th and education was provided on the risks of residents attempting to access other residents' plate settings. A revised policy on how tables will be set and cleaned. Education was also given on the risk of cross contamination and the risk this poses to our elderly population. Colonial Manor will audit R9 and other identified residents to identify if the corrective actions and system changes lessen the opportunity for R9 and other identified residents to access others plate settings. The infection control nurse and social service director will audit R9 and other identified residents. They will audit 10 meals weekly for one month. If audits are going well, they will audit 5 meals weekly for 2 months or until resolved. The dietary manager or designee will audit to assure the table setting is being done per updated policy. They will audit 10 meals weekly for one month. If audits are going well, then 5 meals weekly for 2 months or until resolved. If the table setting policy is not working for this plan, it will be revisited with the IDT and QA committee to be revised as needed. All results of the audits will be shared and reviewed with the monthly and quarterly QA committee until resolved.	

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F 689	Continued From page 3 as needed. Orient and reassure R9 as needed. During an observation on 10/16/23 at 6:46 p.m., R9 was self propelling around the dining room looking at different tables. R9 stopped at R22's table spot, which had left over food and one half a glass of chocolate milk present. R9 took a forkful of food, drank some chocolate milk before staff member (unidentified) who was feeding another resident redirected R9 to her correct table and plate of food. During observation on 10/18/23 at 7:04 a.m., R9 was in the dining room. Dietary aide (DA)-A was only person present in the dining area and was placing beverages on the tables. R9 self propelled herself from table to table taking napkins and placing in her lap, touching the silverware in the process and rearranging silverware on the table. R9 unfolded and refolded the napkins in her lap and then placed them back on different tables. During interview on 10/18/23 at 7:09 a.m., trained medication assistant (TMA)-A indicated R9 doesn't sit still for very long and is frequently up and down the hallways and in and out of the dining room. TMA-A added R9 does go into other residents rooms on occasion and staff try to keep an eye on her when she is in the hallways. TMA-A indicated they used to give R9 old napkins to fold but it never lasts long as R9 can not stay focused on a task anymore. During interview on 10/18/23 at 7:55 a.m., registered nurse (RN)-A indicated try to keep R9 busy but her attention span is very short. RN-A added during meals, staff have to frequently refocus R9 back to her table.	F 689		

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F 689	Continued From page 4 During interview on 10/18/23 at 8:20 a.m., nursing assistant (NA)-A indicated R9 is very busy all day long. NA-A indicated she does go into other rooms but staff try to keep an eye on her to prevent that. NA-A stated she has never seen R9 eat someone else's food. NA-A stated R9 is taken to all activities but sometimes leaves and is up and down the hallways. During interview on 10/18/23 at 9:09 a.m., social services (SS)-A indicated R9 does go to the exit doors on occasion and try's to go outside. SS-A indicated she has never had complaints from other residents about her going into their rooms. SS-A indicated R9 is taken to all activities but she does come and go. SS-A hasn't seen R9 in the dining room except for during meals and activities. During observation on 10/18/23 at 11:00 a.m., R9 self propelled self into a room off the dining room and opened office door where staff was present. Staff redirected her back to the dining room. During interview on 10/19/23 at 10:22 a.m., NA-B indicated R9 used to have a baby doll and some old linen she would fold, but she hasn't seen her doing that since construction started. NA-B indicated R9 does go into other resident rooms and they will put their call light on to have staff come and take her back out of the room. During interview on 10/19/23 at 10:30 a.m., NA-C indicated R9 used to have a baby but is unsure where that is now. NA-C stated R9 frequently goes up and down the hallways and into other resident's room. NA-C has seen her touch other residents silverware but has never seen her eat	F 689		

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F 689	Continued From page 5 other resident's food. NA-C indicated R9 frequently leaves her place at the table and needs redirection to go back and eat. During interview 10/19/23, at 10:17 a.m., dietary aide (DA)-A indicated R9 roams in and out of the dining room all the time. DA-A indicated he has seen R9 go to another table and eat others food. DA-A indicated he has also frequently seen her touch other resident's silverware and napkins that is sitting on the table. During interview on 10/19/23 at 11:23 a.m., the director of nursing (DON) confirmed R9 should not be eating others food, or touching other's silverware. The DON indicated R9's attention span has decreased over the past year and R9 has a difficult time staying on task. The DON indicated R9 is frequently up and down the hallways, but was not aware she was in the dining room unattended. The facility Meal Service policy dated 8/22, included adequate staff should be available in the dining areas to help individuals who need assistance and to handle any situation that may arise. The facility Dining Experience dated 8/22, included the dining room will be cleaned and sanitized after each meal to get ready for the next meal service.	F 689		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		12/1/23

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F 921	Continued From page 6 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a clean and sanitary environment in the kitchen when general cleaning had not been done and when personal items belonging to staff where observed in food prep areas. In addition, 2 of 2 fans in the kitchen were observed with dust and debris, blowing on clean dishes, a food prep (preparation) surface, a convection oven, and an industrial oven/stove. This had potential to affect all 27 residents who consumed food prepared in the kitchen. Findings include: During an observation and interview on 10/16/23 at 1:50 p.m., in the kitchen with cook (C)-A, observed two cell phones belonging to staff on or adjacent to, food prep areas. One phone was located on a counter between a hand washing sink and where C-A had been filling small plastic containers with food. In addition, another phone and personal beverages of staff including a tall, black thermal mug were observed on a shelf above a stainless steel food prep counter, along a plastic bottle of cold coffee and several cans of energy drinks. C-A stated these items belonged to staff; that the items should not have been there, but with a recent renovation of the kitchen, a shelving unit for personal items had not been reinstalled. Further, staff jackets and a backpack were observed in the kitchen on a wire shelf between an industrial refrigerator and a hand washing sink, near a food prep counter. During further observation of the kitchen and dishmachine room with C-A, the following was	F 921	This Plan of correction constitutes our written allegation of compliance for the deficiency cited. No residents were directly affected by the deficient practice however all the residents had the potential to be affected. On November 8, 2023, all dietary staff had an educational meeting on the importance of a clean and sanitary kitchen. The kitchen staff along with other team members, performed a thorough cleaning of the kitchen. Oscillating fans were cleaned and are on a weekly cleaning schedule. Staff personal items are stored in a designated area, outside of the kitchen. Kitchen staff have been instructed that staff beverage containers and personal items are not to be stored in the kitchen in the food prep areas. Task lists were reviewed and updated by the interim dietary manager and reviewed with the dietary staff. The kitchen cleanliness policy was reviewed, updated, and reviewed with the dietary staff. In order to assure that the kitchen cleanliness is maintained, the Dietary Manager or designee will audit the checklists on a weekly basis for two months. At this time, it will be reviewed to determine the frequency. The Administrator or designee will audit the kitchen monthly for 3 months in reviewing checklists while inspecting the kitchen. All	

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F 921	Continued From page 7 observed: 1. Two side-by-side wire shelving units, one silver with six shelves and one black with five shelves, contained stainless steel pans, utensils and other kitchen items. The shelving units had been heavily soiled with gray fuzzy debris on all surfaces of the wire. In addition, the bottom shelves of each unit did not have a solid surface, allowing dust and debris from the floor to contaminate surfaces of items, including pans which had been stacked upside down on the bottom shelf. 2. Two wall mounted fans, both oscillating; one in the dishmachine room and one in the food prep area, both approximately 24 inches in diameter had dark material on the perimeter of all blades and fuzzy gray material on the front wire grate. 3. A stainless steel milk cooler with a top access door had multiple dried liquid stains running down the front of it. 4. The top of the convection oven had visible dust and debris on it; as did the side stainless steel panel of the industrial oven/store, which resembled saw dust. 5. On the underside of a brand new cupboard, was a significant amount of dust/saw dust. C-A stated the kitchen has recently undergone renovation, and they had moved back into the new kitchen about two week ago. At this same time, C-A stated the dietary manager resigned. C-A stated she had been helping to fill that role until another manager could be hired. C-A stated she had been in the process of developing new cleaning lists for the dietary staff. During an interview on 10/17/23 at 9:32 a.m., registered dietician (RD)-C was informed of concerns related to cleanliness in the kitchen.	F 921	results of the audits will be shared and reviewed with the monthly and quarterly QA committee until resolved.	

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F 921	Continued From page 8 RD-C stated she had not been aware; stating she had been conducting kitchen audits prior to the renovation project but had not resumed them. During an observation and interview on 10/17/23 at 2:08 p.m., observed the wall-mounted fan in the dishmachine room oscillating and blowing on clean dishes that were approximately 8-10 feet away. Dietary aide (DA)-A shut off the fan and when it stopped oscillating, stated, "Oh, it's dirty." Observed each blade on the fan had dark debris around it's perimeter and the front grate had gray material on it. DA-A stated the fan had been used to dry dishes coming out of the dishmachine in order to dry them quicker. During an interview and observation on 10/17/23 at 02:45 p.m., in the kitchen with the assistant administrator (AA)-B, walked through each of the cleanliness findings. AA-B was not aware. AA-B stated the kitchen was recently remodeled as part of a facility construction project; the kitchen was taken out of operation on 9/18/23 and placed back in operation on 10/9/23. During an interview and observation on 10/18/23 at 10:29 a.m., C-A stated the fan in the dishmachine room was for staff comfort and shouldn't be used to dry dishes. C-A stated staff were to set racks of dishes at an angle on an empty counter in the kitchen to dry. C-A stated she had requested to AA-C to have a dietary staff meeting to discuss topics such as cleanliness and drying dishes. During a telephone interview on 10/18/23 at 1:57 p.m., RD-C stated most of the facilities she went to used a fan to aid in drying dishes, but that the fan needed to be clean and should be on a	F 921		

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	245572	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 921	Continued From page 9 cleaning list to ensure it was cleaned regularly. During an interview and observation and 10/19/23 at 1:46 p.m., in the kitchen together with AA-B and C-A, reviewed findings in order for both to hear it at the same time. C-A admitted a deep clean of the kitchen had not been done after the remodeling project had been completed and before moving back into the kitchen. AA-B acknowledged this should have been done and would start working with staff on doing that. A policy on maintaining kitchen cleanliness was requested and not provided.	F 921		

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	245572	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/18/2023. At the time of this survey, Colonial Manor Nursing Homewas found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/08/2023

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

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K 000	Continued From page 2 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 capacity of 37 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to test emergency lights per NFPA 101 (2012 edition), Life Safety Code, sections 7.9. and 19.2.9.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 10/18/2023 at 1045AM, it was revealed by a review of available documentation that there was no documentation available to review showing that the annual 90 minute test was conducted. An interview with Adminstrator verified this deficient finding at the time of discovery.	K 291	This Plan of correction constitutes our written allegation of compliance for the deficiency cited. Colonial Manor provided education to the environmental services director on the NFPA code as it relates to emergency lighting 90-minute testing annually. The Environmental Services Director on November 2, 2023 commpleted the 90-minute annual test on all emergency battery lighting. It has been logged into the maintenance logbook. In order to assure the testing gets completed annually the Environmental Services Director has placed the annual test into his calendar. The administrator has placed this in her calendar to assure in the next calendar year she can verify the test has been completed with the	11/2/23

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K 291	Continued From page 3	K 291	Environmental Services Director. The ESD will be responsible to maintain compliance. Completion date is 11/2/2023	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to inspect the kitchen fire suppression system per NFPA 101 (2012 edition), Life Safety	K 324	This Plan of correction constitutes our written allegation of compliance for the deficiency cited. The Environmental Services Director contacted the facilities	12/1/23

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K 324	Continued From page 4 Code, sections 19.3.2.5.1 through 19.3.2.5.5 and section 9.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/18/2023 at 1030AM, it was revealed by a review of available documentation that the last semi-annual kitchen fire suppression system was conducted on 03/07/2023. An interview with Adminstrator verified this deficient finding at the time of discovery	K 324	outside vendor to schedule the inspection of the semi-annual fire suppression system. The vendor will be completing the inspection at Colonial Manor in the next month. Monitoring of compliance will be the responsibility of the Environmental Services Director. To assure the practice is not deficient, the ESD has placed a reminder call to the vendor on his calendar to assure we are on schedule with them semi-annually. The administrator has also placed the next semi-annual inspection date on her calendar to assure the inspection is completed and that ESD is monitoring it. Completion date of 12/1/2023	