



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 27, 2026

Administrator

COLONIAL MANOR NURSING HOME

403 COLONIAL AVENUE

LAKEFIELD, MN 56150

RE: CCN: 245572

Cycle Start Date: July 9, 2026

Dear Administrator:

On July 9, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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.

- 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
 Health Regulation Division
 Minnesota Department of Health
 Rochester District Office
 3425 40th Avenue NW, Suite 115
 Rochester, MN 55901
 Email: Lisa.Krebs@state.mn.us
 Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by **October 9, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **January 9, 2027** (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE , LAKEFIELD, Minnesota, 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
F0000	INITIAL COMMENTS On 7/9/2026, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H55723193C (3072684) with deficiencies issued at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/05/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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			F0609	R1 was immediately assessed to ensure there were no additional physical or psychosocial concerns related to the allegation. The employee identified as the alleged perpetrator was placed on suspension and removed from their nursing duties. After the full investigation, employee was terminated from their employment and the board of nursing notified. All other residents have the potential to be affected. The facility completed interviews with other resident to identify any further safety concerns of resident(s). No concerns were identified. The facility reviewed and revised the abuse prevention policy to reflect current CMS regulations regarding reporting an incident of alleged maltreatment. Policy revisions include: any reported allegation is to be reported within 2 hours of the known incident; language that states both the DON		08/05/2026

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 reverse for further 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.

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

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F0609 SS = D	Continued from page 1 (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was reported timely to the State Survey Agency (SA) for 1 of 1 resident (R1) reviewed for allegations of abuse. In addition, the facility's Abuse Prevention Policy contained outdated reporting requirements that were inconsistent with current federal regulations and did not provide staff with accurate direction regarding required State Agency reporting timeframes. Findings include A Facility Reported Incident (FRI) submitted to the SA on 7/7/26 at 5:13 p.m., alleged caregiver abuse when registered nurse (RN)-A verbalized profanity at and abruptly stopped supporting R1's weight, causing him to fall backward into the bed. A previous report was submitted to the Minnesota Adult Abuse Reporting Center on 7/4/26 at 12:20 p.m., which identified the same information. During an interview on 7/9/26 at 4:05 p.m., licensed practical nurse (LPN)-A stated she witnessed the incident of abuse on 7/4/26 at 6:30 a.m., and left a voicemail for the director of nursing (DON) at 6:45 a.m. and then left the facility. LPN-A stated she did not notify the administrator and did not submit a report to the SA. During an interview on 7/9/26 at 1:11 p.m., RN-B stated she was notified of the allegation of abuse on 7/4/26 at 10:04 a.m. by the DON. The DON requested RN-B replace RN-A due to the abuse allegation. RN-B stated she submitted a report to the MAARC system and not to the SA at 12:20 p.m. RN-B stated she was new and did not know the			F0609	Continued from page 1 and Administrator are to be notified of a suspected maltreatment, along with an operational guidance on reporting. Facility licensed nurses were educated on July 14, 2026, on the need to report within 2 hours of a reported incident using the online reporting portal, along with policy revisions. A guide is available to required employees who report to the online OHFC portal to assist them on the reporting process. On July 29, 2026, the Director of Nursing continued education to licensed nursing staff on the OHFC reporting regulations and process. Annual competency review will be completed with all required reporting employees. To ensure that the facility reports allegations timely, the Administrator or Designee will audit all VA reports submitted to OHFC for the next 3 months to ensure timely reporting and that appropriate action was taken. The Administrator or designee will do 5 random audits each month for 3 months by asking required personnel that report online to show how they report online and when to report. The audit results will be reviewed by the QA Committee and will determine compliance and the need to continue the audits. Colonial Manor will be in compliance by 08.05.2026		08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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F0609 SS = D	Continued from page 2 proper process for filing a FRI to the SA. During an interview on 7/9/26 at 1:37 p.m., RN-A stated she was late for work the morning of 7/4/26 and had a bad morning. She explained R1 had attempted to self-transfer, was not cooperative, and wanted to go home. RN-A responded to assist and stated to R1, "I can't wait until you can get the f*** [foul language]out of here either". RN-A stated she knew it was not professional but R1 was "belligerent" and although unprofessional, did not feel that it was abusive. R1 indicated her employment at the facility was terminated because of the incident. During an interview on 7/9/26 at 2:05 p.m., the DON stated she did not hear her phone call from LPN-A at 6:45 a.m. but did receive the voicemail at approximately 10:00 a.m. and called the facility for more information. The DON called RN-B to replace RN-A and notified the administrator. The DON stated it was her expectation that if staff cannot reach her directly, they are to call the administrator immediately and file a report to the SA. During an interview on 7/9/26 at 3:29 p.m., the administrator identified the DON notified her of the alleged abuse incident on 7/4/26 at 10:44 a.m. (over four hours after the allegation of abuse). The administrator indicated it was her expectation that staff notify the DON or administrator immediately and file a report to the SA according to the facility abuse prevention policy. The facility's Abuse Prevention Plan, reviewed January 12, 2011, directed staff to report suspected maltreatment to the Common Entry Point and the Office of Health Facility Complaints (OHFC) and defined "immediately" as within 24 hours after discovery. The policy did not reflect current federal reporting requirements requiring allegations involving abuse to be reported to the State Survey Agency no later than two hours after discovery. The outdated policy failed to provide staff with accurate guidance regarding current reporting obligations.			F0609			08/05/2026
F0610 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			F0610	R1 was immediately assessed to ensure there were no additional physical or psychosocial concerns related to the allegation. The employee identified as the alleged perpetrator was placed on suspension and removed from their nursing duties. After the full investigation, employee was terminated from their		08/05/2026

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F0610 SS = D	Continued from page 3 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 implement immediate protective measures for resident protection after staff witnessed a co-worker subject 1 of 1 resident (R1) to alleged abuse in the form of derogatory verbiage and actions that caused R1 to fall backwards onto the bed. As a result of this failure, the alleged perpetrator continued to provide care to R1, along with other residents, for approximately four hours after the witnessed allegation with the potential to affect all residents who resided in the facility. Findings include: A Facility Reported Incident (FRI) submitted to the State Agency on 7/7/26 at 5:13 p.m., alleged caregiver abuse when registered nurse (RN)-A verbalized profanity at and abruptly stopped supporting R1's weight, causing him to fall backward into the bed. A previous report was submitted to the Minnesota Adult Abuse Reporting Center on 7/4/26 at 12:20 p.m., which identified the same information. R1's entry Minimum Data Set (MDS) identified R1 was admitted to the facility on 6/29/26. R1's Continuity of Care document identified diagnoses of hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke); anxiety disorder; obesity; delirium (mental state that results			F0610	Continued from page 3 employment and the board of nursing notified. All other residents have the potential to be affected. The facility completed interviews with other resident to identify any further safety concerns of employee(s). No concerns were identified. The facility reviewed and revised the abuse prevention policy to reflect current CMS regulations regarding reporting an incident of alleged maltreatment. Policy revisions included any reported allegation is to be reported within 2 hours of the known incident; language that states both DON and Administrator are to be notified, guidance on the reporting and investigating process. All newly hired employees will be required to complete education on the VA policy and procedures during onboarding. Facility licensed nurses were educated on July 14, 2026, to review the revised policy and procedure. On August 13, 2026, all other facility staff will be educated on the revised policy and procedure. On August 5, 2026, an email on the revised policy was sent to all staff. To ensure facility staff understand the importance of implementing protective measures on an alleged maltreatment incident, Colonial Manor will ask 5 random staff monthly for 3 months to identify safety measures within scenarios provided. The audit results will be reviewed by the QA Committee and will determine compliance and the need to continue further education. Colonial Manor will be in compliance by 08.05.2026		08/05/2026

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F0610 SS = D	Continued from page 4 in confusion, disorientation, and lack the ability to think or remember clearly); and spinal stenosis. R1's brief interview for mental status (BIMS) dated 7/1/26, indicated R1 had severe cognitive impairment. During an interview on 7/9/26 at 10:37 a.m., with R1 and his son, R1 indicated he was new to the facility and although he could not remember the day or time, he did describe an incident when an unidentified staff was "volatile" and the situation "got out of control." R1 stated he did not ever want her to care for him again. During an interview on 7/9/26 at 4:05 p.m., licensed practical nurse (LPN)-A stated she witnessed the incident of abuse on 7/4/26 at 6:30 a.m., and left a voicemail for the director of nursing (DON) at 6:45 a.m. She then left the facility at 6:45 a.m., in which RN-A was the lone charge nurse. During an interview on 7/9/26 at 2:48 p.m., nursing assistant (NA)-A indicated she witnessed the alleged abuse incident on 7/4/26 at 6:30 a.m. NA-A indicated RN-A raised her voice and used foul language, like the "F-word," towards R1, which made R1's behaviors worse. NA-A stated RN-A continued caring for residents until approximately 10:30 a.m. and described the work environment during that period as "extremely uncomfortable" as RN-A remained responsible for resident care after the alleged abuse. During an interview on 7/9/26 at 1:11 p.m., RN-B stated she was notified of the allegation of abuse on 7/4/26 at 10:04 a.m. by the DON. The DON had requested RN-B replace RN-A due to the abuse allegation. RN-B stated she arrived at approximately 10:30 a.m. and RN-A left the building at that time (four hours after the alleged abuse incident). During an interview on 7/9/26 at 2:05 p.m., the DON stated she did not hear her phone call from LPN-A at 6:45 a.m. but did receive the voicemail at approximately 10:00 a.m. The DON received reports that NA staff feared for resident safety as RN-A continued working and they felt uncomfortable working with RN-A. The DON called RN-B to replace RN-A and notified the administrator. The DON stated			F0610			08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE , LAKEFIELD, Minnesota, 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
F0610 SS = D	Continued from page 5 RN-A should have been immediately suspended and removed from resident care pending the investigation and acknowledged RN-A remained the acting charge nurse until RN-B arrived at approximately 10:30 a.m. The DON explained the facility had yet to complete abuse training with staff related to facility expectations and the identified failures in light of the allegation; however, had a meeting scheduled for later in July and would discuss it at that time. During an interview on 7/9/26 at 3:29 p.m., the administrator identified the DON notified her of the alleged abuse incident on 7/4/26 at 10:44 a.m. (over four hours after the allegation of abuse). Further identified the alleged abuse incident occurred on 7/4/26 at 6:30 a.m.; LPN-A left the facility at 6:49 a.m.; RN-B had arrived at 10:30 a.m. which resulted in RN-A continuing to care for R1 and all the residents in the facility unsupervised for approximately four hours. The administrator indicated it was her expectation that staff would notify the DON or administrator immediately; RN-A should have been immediately suspended and removed from duty; and LPN-A should have stayed until RN-B arrived. The facility's Abuse Prevention Plan last updated 1/12/2011, identified it is the policy of Colonial Manor, in accordance with the Vulnerable Adults Act of the State of Minnesota and Centers for Medicare and Medicaid Services (CMS), that all residents residing in the facility will be protected from maltreatment. Residents, the alleged perpetrator, and other staff will be protected from harm during an investigation. The facility will ensure the residents' psychosocial well-being as related to the incident under investigation. Although the Abuse Prevention Plan stated residents would be protected during an investigation, the policy failed to provide operational guidance for immediate implementation of protective measures, including removal of the alleged perpetrator from resident care when supervisory staff were unavailable. The absence of clear direction was consistent with staff uncertainty demonstrated during this event.			F0610			08/05/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/9/2026, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaint was reviewed during the survey: H55723193C (3072684). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.			20000			08/05/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			08/05/2026