STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165476	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manors of Columbus Community	814 Springer Avenue Columbus Junction, IA 52738

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure accurate resident code status (resident decision to have cardiopulmonary resuscitation (CPR) performed or do not resuscitate (DNR) in the event of cardiac arrest) information recorded and readily available for 1 of 16 residents (Resident #24) reviewed for code status. The facility reported a census of 30 residents. The Minimum Data Set (MDS) assessment for Resident #17, dated [DATE], identified the resident had a diagnoses of cerebral vascular accident and dementia, and a Brief Interview for Mental Status score of 11 out of 15 (indicative of moderate mental impairment). On [DATE] at 3:44 PM, observation of the outside cover of Resident #17's hard clinical chart revealed an attached label, titled CPR (which indicated staff were to perform CPR in the event of a respiratory or cardiac arrest). Review of the contents of the clinical record in the hard chart revealed a a form located in the front section of the chart, titled Cardiopulmonary Resuscitation, and included an order for CPR to be initiated in the event of cardiac or respiratory arrest. Resident #24 signed the form on [DATE], and the physician signed the form on [DATE]. The hard chart included documentation of a second form in a separate section of the resident's chart, titled Iowa Physician Order for Scope of Treatment (IPOST), which included an order for the resident to be DNR. The resident's durable power of attorney for healthcare (DPOA) and a healthcare practitioner signed the form on [DATE]. On [DATE] at 3:51 PM, during an interview, the Director of Nursing (DON) reported she did not realize that the CPR identification label on the outside of the chart did not get changed when Resident #17 started hospice. A physician order, dated [DATE], included an order Resident #17 to start hospice services. On [DATE] at 3:53, the DON reported staff would look at outside of the hard chart in an emergency to determine whether or not they should perform CPR. The DON reported a plan to update the label on Resident #17's hard chart to DNR status immediately. Review of the facility's policy, titled Advanced Directives, dated [DATE], revealed the facility respected the right of each resident to make decisions regarding their healthcare, including the right to accept or reject care, execute a living will or durable power of attorney, and determine CPR/DNR status.

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.

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

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	165476	A. Building B. Wing	07/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, review of facility incident reports, review of facility policy, family member and staff interview, the facility failed to ensure staff followed their policy for reporting allegations of abuse for 1 of 1 sampled residents (Resident #17) reviewed with an allegation of abuse. The facility reported a census of 30 residents. Review of the Minimum Data Set (MDS) assessment for Resident #17, dated 6/9/25, identified the resident had a diagnosis of dementia. The assessment included a Staff Assessment for Mental Status which indicated Resident #17 had short term and long term memory problems. The Cognitive Skills for Daily Decision Making assessed the resident as Severely impaired (defined as never/rarely made decisions). The MDS identified the resident required supervision or touch assistance to for a chair/bed-to-chair transfer, transfer to toilet, and tub/shower transfer; and partial or moderate assistance for sit to stand, sit to lying, and lying to sitting on side of bed. Review of the Care Plan for Resident #17,initiated 8/9/23, revealed a Focus area to address [name redacted] is at risk for falling r/t (related to) dementia, inability to recognize safety hazards. Interventions included, in part:a. Ambulate resident with assist x 1 (with one staff) with gait belt. Date initiated: 3/18/25.b. Assist [name redacted] to transfer/ambulate with hand held assistance as she is safe and able. Date revised: 11/14/23. During an interview on 7/21/25 at 5:15 PM, Resident #17's family member reported concerns with the resident having bruising on their wrist about 9 months to 1 year ago. They explained during that same time period that the family member witnessed Staff A, Certified Nurses Aide (CNA), be rough with the resident. The family member stated they saw Staff A grab the resident tightly around the wrists and jerk the resident out of her wheelchair. The family member explained that the family member immediately reprimanded Staff A and told the Administrator. The family member explained the resident already had a bruise on her wrist at the time, and the family member was unsure if the incident the family member witnessed had caused the resident any bruising or injury. The family member could not remember the exact date, day of the week or time of day that the incident occurred. A review completed on 7/23/25 of the facility's Incident/Accident Report forms from August 2024 through July 2025 r/t Resident #17 revealed one report dated 7/9/25. The 7/9/25 report documented the need for a staff to lower the resident to the floor due to weakness. No reports related to Resident #17 found during this time frame. Review of a Non-Pressure Report in Resident #17's clinical record, dated 8/20/24, revealed the resident had a right wrist bruise, deep purple in color and superior to green and yellow bruising. The Non-Pressure Report identified the bruised area healed 9/25/24. During an interview on 7/23/2025 at 10:47 AM, the Administrator denied any reports from family or residents with complaints of rough handling by staff, or concerns of a staff person inappropriately grabbing a resident. The Administrator explained that if she received a report of alleged abuse, she would get a report of what happened, write down the information and investigate. The Administrator reported she would have the staff member give involved in the allegation explain their side of what had happened. The Administrator reported that she would not have that person continue working during the investigation. If there was an allegation of abuse, the Administrator reported she would turn this into the State. During an interview on 7/23/2025 at 10:57 AM, Staff C, CNA, and Staff B, Licensed Practical Nurse (LPN), both reported they had not seen or heard of a staff person that was rough with resident. They had not seen or heard of a staff person grabbing a resident tightly, jerking a resident out of their chair, or inappropriately transferring a resident. During an interview on 7/23/2025 at 11:49 AM, the Director of Nursing (DON) reported she had never had a family member voice concerns in regards to Staff A, CNA, or any other staff. The DON denied having seen or heard of any of the staff inappropriately transferring or being rough with a resident. During a second interview on 7/23/2025 at 12:26 PM, Resident #17's family member reported they misspoke. The family member reported they had not notified the Administrator of the incident they witnessed that involved Staff A, CNA, 9 months to a year ago. The family member recalled they notified the charge nurse when the incident happened with Staff A, CNA. The family member identified the nurse was Staff B, LPN. The family member recalled Staff B, LPN, mentioned the bruising on the resident's wrist, and the family member said to Staff B, I know exactly how it happened. The family member explained they then told Staff B the incident they had witnessed that involved Staff A, CNA. The family member reported they were in the resident's room when Staff A, CNA, grabbed Resident 17's wrists tightly and jerked her out of her (wheel) chair. The family member stated, there was nothing gentle about it. The only persons present in the room when the incident occurred were Resident #17, Resident #17's family member, and Staff A. During an interview on 7/23/2025 at 12:55 PM, Staff B, LPN, when asked if she remembered a family member talking