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	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing Home	403 Colonial Avenue Lakefield, MN 56150

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review the facility failed to revise the care plan for 1 of 1 resident (R1) who had a change with activities of daily living (ADL's). Findings include: R1's admission minimum data set (MDS) dated [DATE], identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to substantial assist with adl's. No signs or symptoms of a possible swallowing disorder. R1's current weight was 178 pounds. R1's significant change MDS, dated [DATE], identified R1 required partial to substantial assist with adl's. Further identified R1 had coughing or choking during meals or when swallowing medications. R1's weight was 160 pounds. R1's Speech Language Pathologist (SLP) communication form to dietary and nursing, dated 6/19/24, identified R1 will need staff assistance with feeding at every meal, will also need frequent cues to sit up, as well as being fed. R1's progress note dated 6/19/24, identified R1 needed staff assistance with feeding at every meal, will need frequent cues to sit up, as well as being fed, staff updated. R1's care plan edited 7/3/24, identified a problem with ADL dependencies; requires assist with adl's related to advanced Alzheimer's disease with significant deficits and inability to care for self. Goal: 6. Eating: R1 will continue to participate in eating through the review date. Approach dated 4/26/24, R1 participated in eating by feeding self after set-up. Does need occasional cueing as needed during eating and drinking. Provide set up to extensive assist at night and as needed. R1's care plan did not identify problems with swallowing or choking on foods or medications nor was it revised to include the SLP orders that R1 needed staff assistance with feeding at every meal, will also need frequent cues to sit up, as well as being fed. During an interview on 7/24/24 at 12:34 p.m. licensed practical nurse (LPN)-A stated, we try to feed R1 if we can, he doesn't make as big of a mess on himself and eats better. R1 can do it, it's just better if we do it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/24 at 12:34 p.m. nursing assistant (NA)-F stated, R1 can feed himself, but R1 eats better when we feed him so we feed him if we can. During an interview on 7/24/24 at 12:44 p.m., DON stated the care plan was not revised to include the speech order from 6/19/24. DON further stated R1 had lost weight, and the dietician had followed up with supplements and a sandwich to given at bed time. In addition, the aides should be documenting how much R1 had eaten with each meal and what level of assist was needed. The nurse working the floor would be responsible to update the care plan and revise when necessary. Facility policy titled, Care plan policy, dated 8/23, the policy identified to assure the care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the residents stay. To assure that the resident and/or their representative, along with the entire care team is involved in the care planning process. To assure the care is planned to attain or maintain the resident's highest physical, mental ad psychosocial well-being .V. Status Change Review a. held as necessary to revise the plan of care, b. The observed change and/or current need is summarized in writing in the medical record and a new plan of approach and goal is developed. c. all participants in the meeting sign their name to indicate the review has occurred. D. if a significant change has occurred, a new MDS will be completed by the assigned disciplines. 39998

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review the facility failed to comprehensively assess, monitor, develop and implement person centered interventions to prevent a pressure ulcer for 1 of 3 residents (R1) reviewed who entered the facility without a pressure ulcer. Findings include: R1's Braden Scale Comprehensive Risk assessment dated [DATE], identified R1 to score a 20 indicating no risk of pressure ulcers. R1 did not use a wheelchair and ambulated without an assistive device. Licensed nurse to assess skin weekly and as needed, will initiate plan of care to put a pressure reducing device for R1's bed. R1's admission minimum data set (MDS) dated [DATE], identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene, and was frequently incontinent bladder and always continent of bowel. R1 was identified at risk for pressure ulcers with interventions of a pressure reducing device for bed and chair. No pressure ulcer was identified. R1's Braden Scale Comprehensive Risk assessment dated [DATE], identified R1 to score a 17 indicating R1 was at risk for pressure ulcers. Interventions included a pressure reducing cushion in bed and a Roho cushion (a pressure relief cushion designed for wheelchairs that's made of flexible air cells connected by small channels) in wheelchair as R1 was now chairfast. R1's progress note dated 5/11/24, identified R1 had a wound which was possible shearing. R1's coccyx wound measured 8 centimeters (cm) x 1 cm. Left open to air and applied barrier cream, will monitor daily. R1's progress note dated 5/27/24, identified the nurse was called to the tub room, upon assessment R2 had sustained two pressure areas on coccyx. Mepilex border dressing (dressing used for exuding pressure ulcers, shields the wound and the silver helps kill bacteria) placed, director of nursing (DON), administrator, case manager and provider updated. Additional note indicated family was notified of pressure areas. R1's progress note dated 5/29/24, identified new orders received for Arginaid (nutritional support to help heal wounds) every day and provider agreed with Mepilex dressing to coccyx to change every 3 days and as needed. R1's progress note dated 5/30/24 identified R1's skin was warm and dry, coccyx area healing, no other skin breakdown noted. R1's May 2024, treatment administration record (TAR) dated 5/27/24, identified the physician order to check Mepilex dressing every shift on coccyx and replace as needed. On 5/30/24, identified the physician order to change Mepilex dressing every 3 days and as needed. No treatment noted to coccyx area from 5/11/24 to 5/27/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's bath sheet dated 6/6/24, identified R1's treatment to pressure ulcer to coccyx was completed. R1's bath sheet dated 6/13/24, identified R1's pressure ulcer to coccyx was healed but will continue to treat as a preventative. R1's Braden skin risk assessment dated [DATE], identified R1 to score a 15 indicating at risk for pressure ulcers. R1 had a pressure ulcer to coccyx, but this has healed see bath sheet 6/13/24, has been using tilt in space wheelchair (helps a person to redistribute pressure), had been incontinent of bowel and bladder. R1's skin observed twice a day with cares and changes are reported to licensed nurse, will have licensed nurse inspect skin weekly and as needed. Will continue with current care plan. R1's significant change MDS, dated [DATE], identified R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene. Further identified R1 was always incontinent bladder and frequently incontinent of bowel. R1 was identified at risk for pressure ulcers with interventions of a pressure reducing device for bed and chair and application of nonsurgical dressings other than to feet. No turning and repositioning program and no pressure ulcer identified. R1's care plan edited 7/3/24, identified a problem that R1 was at risk for skin breakdown related to weakness with inability to reposition self at times, arthritis, gout, coronary artery disease (CAD), peripheral vascular disease (PVD) of bilateral lower extremities and Alzheimer's disease with severe cognitive deficits. Goal: R1 skin will remain intact throughout review date. Approaches: On 4/26/24, turn and reposition R1 in bed (rotate between sides and back) and wheelchair (offload stand if able) per adl section of the care plan. ADL section identified to reposition R1 every 3 hours as needed. On 4/30/24, assess R1 for presence of risk factors, treat, reduce, eliminate risk factors to extent possible. Keep skin clean and dry as possible, minimize skin exposure to moisture, toilet and provide incontinence cares per adl section of the care plan. R1's bath sheet dated 7/13/24, identified R1's coccyx looked fragile in appearance, treatment done per order. Even though R1's Braden scale risk assessments were performed R1's record did not show a causal analysis for the pressure ulcer sustained to coccyx area. Further, it was not evident R1's care plan identified that R1 developed a pressure ulcer or was revised to prevent additional pressure ulcers. In addition, R1's record lacked comprehensive pressure ulcer assessments when R1 developed a pressure ulcer to the coccyx to determine if the treatments that were completed helped heal the pressure ulcer. Record lacked a tissue tolerance test (a pressure test to determine how often a resident should be repositioned to prevent pressure ulcers), lacked daily monitoring of R1's skin and lacked weekly comprehensive wound assessments of R1's pressure ulcer to the coccyx. It lacked staging, characteristics, signs and symptoms of infection, and pain with dressing changes. R1's July 2024, treatment administration record (TAR) identified the physician order to change Mepilex dressing every 3 days and as needed. On 7/20/24 and 7/23/24 it was documented as completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/24/24, at 1:35 p.m. nursing assistant (NA)-E and licensed practical nurse (LPN)-A were observed to toilet R1, Mepilex on coccyx was dated 7/19/24 (indicating the dressing was not changed in accordance with physician order), R1 was placed in the recliner after being toileted. During an interview on 7/24/24 at 1:45 p.m. director of nursing (DON) stated typically with any resident that has a wound they would go on the wound list to be seen by the wound clinic, they are the only ones who do weekly measurements. DON indicated R1 was not on the wound clinic list and was unable to articulate why R1 was never on the list. R1 did have a pressure ulcer to the coccyx but understood it had since healed up and a Mepilex was used for protection. DON stated pressure ulcers were an area that need improvement and are on our radar. Facility policy titled, Skin Care, revised March 2017, identified each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care related to skin care; a person who enters the facility without pressure ulcers does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and the resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing .c. interventions to .g. provide an individualized repositioning program, h. provides daily monitoring of skin condition with at least weekly documentation .j. for existing ulcers: 1. Monitor the ulcers characteristics, 2. Monitor the progress toward healing and potential complications, 3. Assess, treat, and monitor pain if present, 4. Monitor dressing and treatments . 39998

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to develop an individualized toileting program to maintain or improve bowel/bladder continence resulting in a decline in continence for 1 of 1 residents (R1) reviewed for incontinence. Findings include: R1's admission minimum data set (MDS) dated [DATE], identified R1 had severe cognitive impairment and had diagnoses of Alzheimer's disease and anxiety. R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene, and was frequently incontinent bladder and always continent of bowel. R1's Bowel and Bladder assessment initiated on 4/15/24 and was completed on 4/16/24 identified R1 had a trial of a toileting program since urinary incontinence was noted in this facility. R1's toileting program response was unable to determine or trial in progress, R1 was frequently incontinent of bladder and always continent of bowel. R1 required limited assistance with toileting and was usually aware of toileting needs. R1 was identified to have urine leakage without sensation of urine loss, nocturia (greater than 2 times a night) and enuresis (bed wetting). Further identified R1 to have mixed incontinence, had mobility/manual dexterity impairments, lack of ability to get to the toilet or commode/bedpan without staff assist, recognized the appropriate time/place to void and defecate, able to feel the urge to void and was able to feel sensation for bowel movement. R1 appeared to be a good candidate for bowel/bladder retraining program, care plan will be initiated and will have increased episodes of bladder continence with initiation of toileting program and remain always continent of bowels through the review date. R1's care plan will include to toilet R1 prior to breakfast, upon arising from afternoon nap and at bedtime to try and prevent episodes of bladder incontinence. R1 had always been continent of bowels. Bowel pattern has varied between every other day and every third day since admission. Staff to assist R1 as needed or at times R1 will take himself. R1 had significant dementia and will not always communicate toileting needs and will wear a pull-up daily secondary to bladder incontinence. R1's provider orders dated 4/15/24 identified R1 should be toileted in AM prior to breakfast, upon arising from afternoon nap, and at bedtime to try and prevent some episodes of bladder incontinence. R1's record did not include a voiding diary and/or an assessment in order to identify R1's baseline or normal toileting routine in which the aforementioned toileting schedule was developed and implemented. R1's care conference note dated 4/26/24, identified R1 was frequently incontinent of bladder and always continent of bowel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Bowel and Bladder assessment dated [DATE], identified R1 had a trial of a toileting program with no noted improvement. R1 was always incontinent of bladder and always incontinent of bowel. No bowel toileting program being used to manage R1's incontinence. R1 required extensive assistance with toileting. R1 was identified to have urine leakage without sensation or urine loss, nocturia and enuresis. Further identified R1 to have mixed incontinence, had mobility/manual dexterity impairments, lack of ability to get to the toilet or commode/bedpan without staff assist, able to feel the urge to void and able to feel sensation for bowel movement. R1 appeared to be a good candidate for bowel/bladder retraining program, continue to current care plan. R1's significant change MDS, dated [DATE], identified R1 required partial to moderate assistance with toileting and toilet transfers, required substantial assistance with chair/bed transfers and hygiene. Further identified R1 was always incontinent bladder and frequently incontinent of bowel. Even though R1's bowel and bladder assessments and MDS assessments showed a decline in continence, R1's record did not show a causal analysis. Further, it was not evident R1's toileting plan was revised to improve bowel and bladder incontinence and/or prevent decline. Additionally, the record did not indicate the physician was notified of R1's decrease in incontinence. R1's care plan edited 7/3/24, identified a problem with activities of daily living (ADL) dependencies, required assistance with adl's related to advanced Alzheimer's disease with significant memory deficits and inability to care for self. 7. Goal: toileting and continence, R1 will remain always continent of bowels and have decreased incontinence with current bladder retraining program through review date. Approaches: on 4/26/24, toileting plan to toilet R1 per schedule and if noted to be trying himself, R1 was frequently incontinent and required extensive assist of one staff with toileting, and on 4/30/24, R1 was always continent of bowel. R1's Point of Care history identified R1 was supposed to be toileted three times a day. The record reviewed between 5/24/24 to 7/24/24 showed R1 was not always toileted per the care plan. Specific examples between 7/1/24 to 7/24/24 included the following: 7/1/24: toileted x 1 7/2/24: toileted x 1 7/3/24: toileted x 2 7/4/24: toileted x 2 7/5/24: toileted x 1 7/6/24: toileted x 1 7/7/24: toileted x 2 7/8/24: toileted x 3 7/9/24: toileted x 2 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/10/24: toileted x 3 7/11/24: toileted x 1 7/12/24: toileted x 2 7/13/24: toileted x 2 7/14/24: toileted x 1 7/15/24: toileted x 1 7/16/24: toileted x 1 7/17/24: toileted x 2 7/18/24: toileted x 1 7/19/24: not toileted 7/20/24: toileted x 3 7/21/24: toileted x 3 7/22/24: toileted x 2 7/23/24: toileted x 3 7/24/24: toileted x 1 During an observation on 7/24/24 at 1:35 pm, R1 was toileted by staff and had a wet brief. During an interview on 7/24/24 at 1:35 p.m., nursing assistant (NA)-E stated R1 was last toileted at 11:00 am and R1 had voided. During an interview on 7/24/24 at 1:45 p.m., DON stated R1 had a decline in bowel and bladder incontinence, when R1 went from always continent of bowel and frequently incontinent of bladder to always incontinent of bowel and bladder. DON was unable to articulate a treatment and service plan to improve or maintain bowel and bladder. DON stated R1 should have been on a toileting plan to offer toileting every two hours not three times a day. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Bowel and Bladder Policy, revised 8/2023, indicated each resident receives the necessary care and service to attain or maintain the highest practicable level of bowel and bladder continence .2. The comprehensive assessment results are used to develop a care plan addressing the individual needs of each resident. Care plan interventions are determined with consideration of: a. the ability of the resident to make decisions and call for assistance to use the toilet. B. The presence of permanent physical impairment or disease which could prevent incontinence. C. Resident's desire to participate in bowel and bladder programing. D. current standards of practice in accordance with state and federal law. 3. Review of the comprehensive assessment and care plan will occur on at least a quarterly basis and more frequently if there is a change in residents condition . 39998