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	10/28/2024

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 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39998

Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to provide timely assistance with personal cares needs for 7 of 7 residents (R1, R2, R3, R4, R5, R6, and R7) who voiced concerns of inadequate number of staff to routinely meet their needs in a timely manner

Findings include:

A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 10/18/24 alleged the vulnerable adult (VA) would push the call light to request staff assistance to use the bathroom and staff would take an hour to respond. Because of the extended wait time, the VA would not get to the bathroom in time and be incontinent of bowel and urine.

R1

R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had moderately impaired cognition. The MDS identified R1 required staff assistance with toileting, bathing, dressing, bed mobility, and transfers. Diagnoses included diabetes, Alzheimer's disease, history of urinary tract infections (UTI), and congestive heart failure.

R1's care plan last updated 10/16/24, indicated R1 required assistance of one staff and stand lift to transfer to toilet. The care plan did not identify a toileting plan.

During an interview on 10/24/24 at 11:05 a.m., Family member (FM)-A stated R1 had his light on for 1 1/2 hours when she was notified by R1 and had to call the nursing home phone line to reach staff to assist R1 to the bathroom. Further stated R1 was normally continent of bowel but was having diarrhea and could not wait for the 1 1/2 hour call light wait time which result in R1 being incontinent which would be embarrassing to him.

During an interview on 10/29/24 at 3:10 p.m. family member (FM)-B stated she visited R1 daily and would put his call light on when he needed to use the bathroom, but staff would not come. R1 would have to poop his pants which would embarrass him if he were feeling better. FM-B reported greater than 40-minute wait times but often she would shut the call light off and turn it right back on hoping it would get reset and noticed [by staff]. FM-B reported being nervous about leaving him alone in the facility's care.

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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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's call light log for the dates of 9/24/24 to 10/17/24, indicated the following call light wait times: 24 instances of 15-29 minutes; 9 instances of 30 -59 minutes; and one (1) instance of over 60-minute wait time. R2 R2's significant change MDS dated [DATE], indicated R2 had moderately impaired cognition. The MDS identified R2 was dependent on staff for toileting, dressing, and transferring. The MDS did not identify any behaviors or rejection of cares. The MDS identified diagnoses of dementia, history of UTIs, and osteoarthritis. R2's care plan printed 10/24/24, indicated R2 required assistance of two staff and stand lift to transfer. Toileting plan was to toilet resident per his request. During an interview on 10/24/24 at 1:45 p.m., R2 reported staff did not answer his call light promptly and was told the facility had a staff shortage. R2 further reported having been on the commode with his call light on for an hour and it was painful to sit that long on the commode. R2 stated he did not get his baths on a regular basis and often missed them because he was told there was not enough staff to do it. R2 expressed concern that he is prone to urinary tract infections if his catheter drainage bag did not get emptied, he has called and waited for help for extended periods of time to get staff to empty it and has had several occasions when the urine drainage bag backed up which could cause him to have infections and discomfort. Review of R2's call light log for the dates of 9/24/24 to 10/24/24, indicated the following call light wait times: 40 instances of 15-29 minutes and 24 instances from 30 to 59 minutes; and six (6) instances of greater than an hour wait times. R3 R3's quarterly MDS dated [DATE], indicated R3 had intact cognition, no behaviors, and no rejection of cares. The MDS also identified R3 required staff assistance with showering, toileting, and transferring. R3's care plan printed 10/24/24, indicated R3 required staff assist with bathing at least weekly, and assist of two staff and stand aid to transfer to the toilet. During an interview on 10/24/24 at 10:30 a.m., R3 stated, they [staff] do not answer the call lights. R3 reported sometimes he would have to sit on the toilet for over 30 minutes before they would answer his call light. R3 further reported he has tried to get up on his own because he was tired of waiting for staff to answer his call light which caused him to dribble on the floor. R3 described these incidents as being embarrassing and frustrating. R3 stated, what if I was having a heart attack, I would die before anyone answered my light which made him nervous. R3 reported he voiced his concerns about long call light wait times at resident council and has been told they are going to look into it, but nothing changed. Review of R3's call light log for the dates of 9/24/24 to 10/24/24, indicated the following call light wait times: 18 instance of 15-29 minutes and four (4) instances of 30-59 minute wait times. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4 R4's admission MDS dated [DATE], indicated R4 was cognitively intact with no behaviors or rejection of cares. The MDS identified R4 required staff assistance with toileting, bathing, and personal hygiene. The MDS indicated diagnoses of polyosteoarthritis, history of falling, and muscle weakness. R4's care plan printed 10/28/24, indicated R4 required staff assistance and walker with transferring. The care plan also identified R4 was at risk for altered dignity and staff were to ensure hygiene was maintained and had a goal of remaining continent of bowel and bladder which required staff assist with toileting in the morning upon arising, after meals, periods of rest, and night and upon her request. The care plan identified R4 as a fall risk and interventions included staff were to answer her call light promptly. R4 required one staff assist with a weekly shower. During an interview on 10/24/24 at 10:35 a.m., R4 reported being a resident of the facility for about 10 weeks and just got her sixth bath that day. R4 further explained being clean was very important to her and she was scheduled for a weekly bath, but it frequently got canceled because the bath person would get pulled. R4 also reported her call light wait time was sometimes as long as 1 1/2 hours. R4 indicated she has urinary urgency and cannot transfer herself to the bathroom. R4 further stated she cannot wait that long to use the bathroom and will be incontinent of urine because it takes so long to get assistance. R4 also reported she would have to go out to the hallway with her wheelchair to find staff to assist her. Review of R4's call light log for the dates of 9/24/24 to 10/24/24, indicate the following call light wait times: 32 instances of 15-29 minutes; 23 instances of 30-59 minutes; six (6) instances of 60-89 minutes; two (2) instances of 90-119 minutes; and one (1) instance of over 120 minutes or two (2) hour response time. R5 R5's quarterly MDS dated [DATE], indicated R5 has severe cognitive impairment but no behaviors or rejection of cares. The MDS identified R5 required staff assistance with toileting and transferring. The MDS indicated diagnoses of chronic pain, osteoarthritis, diarrhea, overactive bladder, and diabetes. R5's care plan printed 10/24/24, identified R5 was always continent of bowel and frequently incontinent of urine. The care plan further identified R5 required assist of one staff with toileting and was to be toileted per request. During an interview on 10/28/24 at 3:45 p.m., R5 reported she needed staff assistance to use the bathroom but would often be incontinent because it took too long for staff to respond to her call light. R5 estimated it took staff about 20 minutes or so to respond to her call light. Review of R5's call light log for the dates of 9/24/24 to 10/24/24, indicate the following call light wait times: 16 instances of 15-29 minutes; 10 instances of 30-59 minutes; and one (1) instance of over 60-minute wait time. R6 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's quarterly MDS indicated R6 was cognitively intact with no behaviors or rejection of cares. The MDS identified R6 required staff assist with toileting, transferring, bathing, and personal hygiene. The MDS indicated diagnoses of dystonia (movement disorder that causes the muscles to contract and twist involuntarily), osteoarthritis, osteoporosis, overactive bladder, and anxiety disorder. R6's care plan printed 10/28/24, indicated R6 required two staff assist with full body lift to transfer, one staff assist with toileting needs, and toileting plan includes to toilet every evening between 7-8:30 to try to promote bowel continence as able and per her requests. R6 was to receive a weekly whirlpool bath or shower. During an interview on 10/24/24 at 10:10 a.m., R6 reported concerns of waiting for her call light to be answered for 45 minutes or more. R6 further stated, it takes them so long to come, I have to go [urinate] in my brief and reported being embarrassed when she is incontinent. Further reported she did not get her bath when she wants it and sometimes her bath gets skipped because of lack of staff to give baths. Review of R6's call light log for the dates of 9/24/24 to 10/24/24, indicate the following call light wait times: 13 instance of 15-29 minutes; five (5) instances of 30-59 minutes; and one (1) instance over 90 minutes. R7 R7's quarterly MDS dated [DATE] indicated R7 was cognitively intact, no behaviors, and no rejection of cares. The MDS identified R7 was dependent on staff for eating, personal hygiene, toileting, showering, dressing, transfers, and bed mobility. The MDS identified diagnoses as rheumatoid arthritis (a condition that affects the joints), malnutrition, chronic pain, dysphagia (difficulty swallowing), major depressive disorder, and anxiety disorder. R7's care plan printed 10/28/24, indicated R7 required staff assist and full body lift for transferring; staff assist with turning and repositioning at least every 2-3 hours and as needed; and staff were to provide total assistance during eating and drinking at meals. During an interview on 10/24/24 at 2:40 p.m., R7 reported staff do not answer call lights soon enough and often must wait over 30 minutes for staff to respond to her call light. R7 stated she has been told that there is not enough staff but expressed concern because she relies on staff for all her cares including feeding. R7 further explained her meal tray has been forgotten a couple of times so she has not been fed until she put her call light on to remind staff that she had not eaten. R7 reported feeling anxious and nervous at times because of the shortage of staff. Review of R7's call light log for the dates of 9/24/24 to 10/24/24, indicate the following call light wait times: 33 instances of 15-29 minutes; and 12 instances from 30 to 59 minutes wait times. Due to staff's request to remain anonymous due to fear of retaliation, all staff will be referred to as employee (E) and date and time will not be identified. During an interview, employee (E)-A indicated call lights are crazy and there is not enough staff to answer them all. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, (E)-B indicated the facility was short on nursing assistants (NA)s during the days and hears extended wait times a lot but does not answer the lights because they were responsible for other duties. During an interview, (E)-C indicated there were not enough staff to meet the needs of residents and at times only had two NA's on to assist all residents. During an interview, (E)-D indicated there was not enough staff to care for the residents and baths sometimes had to be skipped. Also identified the residents must wait a long time for their call lights to be answered but staff just could not get to them all. During an interview (E)-E indicated resident call lights are excessive and they do have to wait a long time to be answered. Further identified they need more help to meet the resident every day needs. During an interview (E)-F indicated staffing is a concern. Residents complain about long call light wait times but sometimes there are not enough staff to get to them in time. If there were only two NA's and most of the residents take two staff to assist them, there is no one to respond to call lights. During an interview on 10/28/24 at 2:00 p.m., the director of nursing (DON) indicated it is her expectation that resident's call lights be answered in a timely fashion but did not know what time limit she would consider as a timely fashion. Further stated she has educated staff that no matter what they are doing, they need to drop what they are doing to answer call lights to assure the resident is not in an emergent situation. The DON was not aware of a process to track and trend resident call light response times. The DON felt meeting the resident's bathing, toileting, repositioning needs depended on the day, and they were actively recruiting new NA staff. During an interview on 10/28/24 at 3:25 p.m., the interim case manager (CM) indicated there was not a process in place to trend, track, or review the call light response times. The CM further identified the facility staffed to the number of residents but not to the acuity (care level) of the residents. The CM stated the facility census may only be 25 but they have a very high acuity of residents that take multiple staff to assist them with the necessary cares. Review of the Resident Council notes dated 10/11/24, at 2:30 p.m., identified 6 (six) residents were present at the meeting and stated that missed baths were still a concern and that call light times were long. Review of the Quarterly Nursing Report May 2024 - July 2024, identified call light wait times as a concern and indicated call light wait times would be audited to look for patterns, develop strategies to reduce wait times during specific times of the day. During an interview on 10/24/24 at 2:30 p.m., the administrator acknowledged the facility had staffing challenges. During a follow up interview on 10/28/24 at 3:45 p.m., the administrator indicated the facility staffed according to census and acuity. The administrator indicated the facility had enough staff to care for the residents, but staff lacked ambition. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility Assessment indicates the facility's has 37 licensed beds with an average census is 28.23 and average number of floor staff per shift for day shift is one full time (FT) DON (available by phone on weekends, evenings, and nights); one FT case manager (registered nurse (RN)); four to six direct care staff (trained medication aide, certified nurse aide, and a bath aide(BA)). For evening shift: one charge nurse (RN or licensed practical nurse (LPN)); three to five direct care staff (TMA/CNA/BA). For night shift it is one charge nurse (RN or LPN); two to three direct care staff (TMA/CNA/BA). No other information was provided.