

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 In addition, the facility's Abuse Prevention Policy contained outdated reporting requirements that were inconsistent with current federal regulations and did not provide staff with accurate direction regarding required State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 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. (continued on next page)		

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The outdated policy failed to provide staff with accurate guidance regarding current reporting obligations.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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 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 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		