| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245572 | A. Building<br>B. Wing | 01/29/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor Nursing Home | 403 Colonial Avenue<br>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.

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on record review and interviews, the facility failed to have a registered nurse (RN) on duty 8 consecutive hours a day, 7 days a week for 3 of 18 days reviewed.Findings include: Review of the 18 sampled days between 7/1/25 through 1/1/26 identified:On 11/15/25 the RN had only worked 4.5 hours that day.On 7/4/25 there was no RN coverage for that day.On 8/2/25, the RN had only worked 6.25 hours that day. Interview on 1/28/26 at 3:51 p.m., with the health unit coordinator who identified he was responsible for the schedule and to ensure there was an RN working 8 consecutive hours a day. If there was a call-off it was the responsibility of the case manager to work that shift for the RN coverage. He confirmed no RN had worked on 7/4/25. Interview on 1/29/26 at 2:50 p.m., with director of nursing identified that the health unit coordinator was responsible for the schedule and was very good at letting her know if there was not an RN scheduled to work. When that occurred, she revealed that the case manager or herself would provide that RN coverage. The expectation was that the facility would have an RN work 8 consecutive hours a day, 7 days a week. Review of April 2025, Departmental Supervision, Nursing policy identified that the facility would have a licensed nurse (registered nurse, or licensed practical or vocational nurse) on duty 24 hours a day 7 days per week. The policy further identified that an RN would be scheduled to work 8 consecutive hours in a 24-hour period, 7 days a week. |

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 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on observation, interview and document review, the facility failed to designate a qualified person to serve as the director of food service to oversee the dietary department in the absence of a full time dietitian. This had the potential to affect all 26 residents, visitors and staff who consumed food from the kitchen.Findings include: Interview on 1/27/26 at 9:30 a.m. with the dietary manager (DM), identified she was not yet certified and was waiting for direction as to what courses she needed to complete to obtain her certification. She reported she did have her SERV Safe certification and had previously worked as the main cook, prior to taking the position as DM. She reported the facility had a contracted registered dietitian that came to the facility once a week on Tuesdays and was available via phone or email between visits. She identified when the RD came to the facility, she completed the assessments, reviewed dietary items with her, and assigned leaning topics she was to complete online. She reported she had not had anyone work alongside her to provide training in her new role, but she was committed to taking the courses and obtaining her certification. Interview on 1/28/26 at 3:40 p.m. with the RD reported she came to the facility once a week, on Tuesdays to complete the Minimum Data Set (MDS) assessments, review menus, and assist the DM. She reported the DM completed the initial interview with residents to determine preferences, and general information that was documented in the record. Interview on 1/28/26 at 4:09 p.m. with the administrator and the regional director reported they were under the impression that the DM's years of experience met the requirement for the certified dietary manager position. They both confirmed the intent for the DM to complete the required certification coursework, but she had not started as of the date of survey. Following discussion and review of the regulation identified in the State Operation Manual (SOM) they voiced agreement that the facility was not currently in compliance with the regulation. A policy for management of the dietary department was requested but not provided by the end of the survey. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to maintain a clean and sanitary kitchen with appropriately clean food preparation equipment identified as a buildup of dust and grease on exhaust vents and food residue on food preparation equipment. This had the potential to affect all 26 residents who received food prepared in the facility kitchen.Findings include: Based on observation and interview on 1/27/26 at 9:30 a.m. with the dietary manager (DM) the following areas of concern were identified:1) 2 of 2 rectangular exhaust vents located above the doors on the dining room side of the kitchen were covered with a black, thick, furry appearing substance. The vents were pointed toward the stove and food preparation areas.2) Vents on the refrigerator and freezer on the dining room side of the kitchen, were covered with a thick layer of dust, and the dust was noted to be moved by the circulating air.3) A chest type (milk) cooler positioned between the refrigerator and freezer on the dining room side of the kitchen, had a red liquid dried on the inside seal, in addition to a buildup of dirt and food residue.4) Dried red liquid was noted on the floor, along the base of the refrigerator and splattered on the lower portion of refrigerator. The DM identified the dried liquid as juice that had spilled on 1/26/26 and not been cleaned up.5) A stand mixer on the counter had orange colored residue splattered on the frame and head of the mixer, which the DM identified as food residue. She was not able to identify the residue, and she stated she was not aware of when the mixer had last been used.6) A metal rack was positioned on the back side of the electric range and hood with a plexiglass barrier behind it which contained spatters of grease and dust from the range. The rack contained steam table pans, and cooking equipment. The DM identified the barrier had a buildup that should have been cleaned daily but had not been done.7) Exhaust vents facing the rack behand the range, and over the doors on the opposite end of the kitchen also had an accumulation of dust and grease that had the potential of blowing onto food being prepared.8) A table mounted can opener had black buildup surrounding the blade of the opener and would have come in contact with the inner surface of a can being opened. The DM identified the substance as food residue and reported she had not noticed this previously and reported it needed to be put in the dishwasher for cleaning. The DM reported she had begun preparing cleaning schedules, but she had not noticed the areas identified and confirmed they needed to be cleaned. She stated she was new to the position and was finding she needed to have cleaning schedules for daily, weekly, and monthly tasks to be completed because the cleaning was not being done. She identified she had not implemented her cleaning schedules as of the date of survey and would be contacting maintenance to clean the vents, and to put on a schedule for cleaning. Observation and interview on 1/27/26 at 11:15 a.m. with the administrator noted the areas of concern and confirmed the need for development of cleaning schedules and maintenance would be notified of the need to clean the vents in the kitchen on a regular basis. A policy was requested for cleaning of the kitchen and equipment but not provided by the end of the survey period. |

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| F 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>The facility failed to submit accurate staffing information for payroll-based journal (PBJ) for 1 of 4 quarters (quarter 4) reviewed.Findings include: Review of 2025, quarter 4 PBJ staffing Data Report 1705D identified the facility failed to have licensed nursing coverage 24 hours a day. The report identified the following dates 7/4/25 Friday, 7/5/25 Saturday, 7/6/25 Sunday, 7/19/25 Saturday, 7/20/25 Sunday, 8/2/25 Saturday, 8/3/25 Sunday, 8/9/25 Saturday, 8/10/25 Sunday, 8/17/25 Sunday, 8/30/25 Saturday, 9/13/25 Saturday, and 9/27/25 Saturday. Review of the above dates and facility staff timecard punches for the dates identified, showed that the facility did have licensed staff on duty each shift on each day identified. Interview on 1/27/26 at 3:15 p.m., with the regional director of skill operations identified there had been PBJ issues at each of the facilities she consulted. She reported the facility had not been without 24 hours licensed nursing staff and she was unsure why that had triggered for the facility. The business office manager was responsible for submitting the PBJ data and she also completed audits on the data she submitted. Interview on 1/29/26 at 1:30 p.m., with business office manager confirmed she was responsible for submitting the facility PBJ data. She revealed she had not previously reviewed the 1702D report until it had been requested during this survey. She found with the review that one of the full time licensed practical nurses (LPN)-B was not pulling from their payroll system into the PBJ report. LPN-B worked most of the days in question. She was still investigating why the report had been triggered on the other days. She confirmed that there had been inaccurate PBJ reporting completed. Review of the undated, Payroll Based Journaling (PBJ) policy identified the facility would regularly compile and submit PBJ reports that provided data on staffing levels. The facility would use attendance software databased to assist with reporting. The facility would verify submission by checking the validation report once submitted. The facility could take steps to streamline workflow to help track staffing-related data. Use automated payroll processes, implement processes for staff to clock-in and clock-out for hourly tracking, adopt in-house systems that automatically generate reports, regularly audit PBJ files and data prior to submitting reports, and train and educate staff involved in PBJ data collection and submission. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on interview and document review the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee for improvements had a developed measurable goal, action plan identified to reach the goal and analysis of the data collected on the improvement activities. This had the potential to affect all 26 residents residing in the facility.Findings include: Review of the quarterly QAPI meeting minutes provided identified:1) QAPI meeting minutes from 2/18/25, identified agenda for February, March, and April, included dietary review, diagnosis of malnutrition, at-risk of malnutrition, supplements, fluid restrictions, modified diets, low body mass index (BMI), high BMI's, and weight loss. Included with the documentation was a weight variance report from 1/18/25 through 2/18/25, which listed the residents' name and their weights, their BMI, and any change in weight. There was no identified goal, no action plans, or analysis of the data that was brought forth.2) QAPI meeting minutes from 5/15/25, identified agenda for February, March, and April, included dietary review, diagnosis of malnutrition with 3 residents listed, at-risk of malnutrition with 1 resident listed, supplements with 8 residents listed, fluid restrictions with 1 resident listed, modified diets with 7 residents listed, low BMI's with 2 residents listed, high BMI's with 10 residents listed, and weight loss with 1 resident listed. There was no identified goal, no action plans, or analysis of the data that was brought forth.3) QAPI meeting minutes from 8/19/25, identified agenda for May, June, and July included infection control updates, COVID-19 updates, current audits, accident/incident reports, pharmacist consultant reports, medication error, antibiotic stewardship, quality improvement projects, social service report, dietary report and environmental services. There was no documentation of any new concerns brought forth nor was there any indication that the committee reviewed or analysis the previously identified concerns. 4) QAPI meeting minutes from 12/16/25, identified agenda for December, included infection control updates, COVID-19 updates, current audits, accident/incident reports, pharmacist consultant report, medication errors, pressure ulcer, antibiotic stewardship, quality improvement projects, dietician report, and environmental services. There was no documentation of any new concerns brought forth nor was there any indication that the committee reviewed or analysis the previously identified concerns. Review of the quality improvement project for 2025 through 2026 identified: 1) The goal was to decrease the call light response times. Data would be collected from residents, the call light system and to identify any trends. 2) The goal was to decrease the number of skin concerns. The team will implement new wound strategies, educate staff on skin breakdown and prevention along with partnering with an outside wound care company. There was no measurable goal identified for either the call light times, or the skin issues identified. Interview on 1/29/26 at 4:00 p.m., with quality assurance director, regional administrator, and the administrator identified that concerns were brought forth to the QAPI committee via resident surveys, staff reports, grievances, and resident council. When concerns were identified the committee would come up with a plan to correct the concerns. The regional administrator confirmed that the facility had information related to concerns brought forth to the QAPI committee however, that information was not identified in the QAPI minutes. The facility was currently working on 2 areas, skin and call light times. She confirmed neither concern had a measurable goal identified however, the facility was working on reducing skin issues and long call light wait times in general. They reported the facility had interventions in place but did not do any documentation in the QAPI minutes or that the information had been reviewed by the committee. The quality assurance director identified that the facility had been through 5 nurse directors in the last year, there had been a turnover of management and that she was aware the QAPI committee was lacking documentation and structure. She had been trying to attend some of the QAPI meetings and planned to complete audits to give to the committee for some feedback. She also had reached out to the facilities consulting provider for some guidance on what needed to be documented in the QAPI meeting minutes. The quality assurance director, regional administrator and administrator agreed that<br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | the QAPI meeting minutes for improvement projects lacked documentation of an identified measurable goal, interventions, and analysis of any data brought forth. Review of the July 2025, Quality Assurance & Performance Improvement plan (QAPI) identified the facility would take a proactive approach to improve the way they cared for residents. The organization made decisions based on data from input from caregivers, residents, health practitioners, families and other stakeholders. Data may be gathered from a data collection system such as Trend Tracker, Matrix Care, and surveys. The facility would set goals and measure progress towards those goals. The administrator was responsible for overseeing the QAPI committee. The committee will decide on what data to monitor with priority given to QA committee project recommendations. The QAPI team will review information from sources to determine if gaps or patterns exist in the facility systems of care that could result in quality problems and if there were opportunities to make improvements. Once a concern or issue was identified the QAPI team would prioritize and determine which problem will become the focus for a performance improvement project (PIP). The facility will then outline who would be entrusted with a mission to investigate and produce plans for correction and/or improvement to be implemented. At a minimum PIP team members would be given resources and guidance on how to develop and process improvements. The improvement team will report monthly to the QA committee/QAPI committee via a report or in person if requested or additional information was needed. The facility would take a systematic approach to determine when an in-depth analysis was needed to understand the problem, its causes, and implications of a change. The facility was to comprehensively assess all involved systems to prevent future events and promote sustained improvements. Staff were encouraged to use root cause analysis to identify the core of the system breakdown. The facility would at a minimum report the progress on the established QAPI goals, PIP plans and current data trends to the leadership, staff, and resident and family council. The team would thoughtfully and thoroughly consider the progress made in the last year toward achieving the QAPI goals and status of sustaining the performance indicators. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on interview and document review the facility failed to ensure the infection preventionist (IP) brought a thorough report to the Quality Assurance Performance Improvement (QAPI) meetings on the infection control program.<br><br>Findings include:<br><br>Review of the 2/18/25, 5/15/25, 8/19/25, and 12/16/25 quarterly QAPI information provided, was a sign in sheet and an agenda for the meeting. There were no minutes provided.<br><br>Interview on 1/28/26 at 8:24 a.m., with the interim director of nursing (IDON) who was the facility designated infection preventionist identified when staff called off for their shift the manager for their department filled out a form that was sent to the health unit coordinator (HUC) and he was responsible for tracking staff illness. The IDON revealed that she did not track, analyze or include staff illness in her QAPI reports and that staff illness was not discussed at QAPI. She was responsible for overseeing the infection control program. She reported she was certified in another state; however, she was unable to provide any information on completion of a program or certificate to confirm that.<br><br>Interview on 1/28/26 at 2:13 p.m., with the regional administrator identified that the IDON was originally hired for the director of nursing role. When the facilities IP abruptly left her employment the IDON took on the IP responsibilities. She was aware that the IDON was not certified for infection control. She agreed that anyone working at the facility as the IP should either be certified by an approved infection preventionist training program or be enrolled in a program to become certified as an IP.<br><br>Review of the undated, Infection Prevention Surveillance policy identified the IP would develop and maintain systems to gather surveillance data for both residents and staff, compile and analyze the data, utilize the findings to direct infection control activities and report those findings to the QAPI committee.<br><br>Review of the 2/18/25, 5/15/25, 8/19/25, and 12/16/25 quarterly QAPI information provided, was a sign in sheet and an agenda for the meeting. There were no minutes provided.<br><br>Interview on 1/28/26 at 8:24 a.m., with the interim director of nursing (IDON) who was the facility designated infection preventionist identified when staff called off for their shift the manager for their department filled out a form that was sent to the health unit coordinator (HUC) and he was responsible for tracking staff illness. The IDON revealed that she did not track, analyze or include staff illness in her QAPI reports and that staff illness was not discussed at QAPI. She was responsible for overseeing the infection control program. She reported she was certified in another state; however, she was unable to provide any information on completion of a program or certificate to confirm that.<br><br>Interview on 1/28/26 at 2:13 p.m., with the regional administrator identified that the IDON was originally hired for the director of nursing role. When the facilities IP abruptly left her employment the IDON took on the IP responsibilities. She was aware that the IDON was not certified for infection control. She agreed that anyone working at the facility as the IP should either be certified by an<br>(continued on next page) |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | approved infection preventionist training program or be enrolled in a program to become certified as an IP.<br><br>Review of the undated, Infection Prevention Surveillance policy identified the IP would develop and maintain systems to gather surveillance data for both residents and staff, compile and analyze the data, utilize the findings to direct infection control activities and report those findings to the QAPI committee. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employees would be able to return to work after an illness dependent upon their symptoms for 3 of 3 months reviewed. This has the potential to affect all 26 residents who resided at the facility.Review of the facility staff illness surveillance identified the following1.On 10/13/25 licensed practical nurse (LPN)-A called in for his shift with symptoms of glassy eyes, sore throat, and feeling sick. The surveillance did not identify the last day worked, the date symptoms resolved, or when LPN-A returned to work.2.On 10/20/25 nursing assistant (NA)-A called in with symptoms of a sore throat and a temperature of 100.1. Her last day worked was 10/19/25. The staff illness log did not identify when NA-A was eligible to return to work or her actual return to work date. Under a column labeled notes it said she had been gone a few days, and she brought in a physician note.3.On 11/25/26 the facilities health unit coordinator (HUC) called in with symptoms of nausea, vomiting, chills, fever, headache, and body aches. The symptom onset date was 11/25/25. The log did not identify when his symptoms were resolved, when he was eligible to return to work, or what day he returned to work.4.On 12/19/25, NA-A called in with symptoms of sick. The log did not identify any other symptoms, no onset date, no resolution date, no eligible to return to work date, and no actual date that NA-A did return to work. The notes column identified that she was out for multiple days until signs and symptoms stopped. Interview on 1/28/26 at 8:24 a.m., with the facility designated infection preventionist identified that when staff call in for their shift, the department head fills out a form that is given to the facility health unit coordinator (HUC) and he was responsible for tracking staff illnesses. She identified that he would let her know if staff called in with symptoms that may be related to an infection. She identified she had not included any information on staff illness in her monthly infection control summaries, and she was unable to provide any documentation or actions to indicate she was involved in overseeing staff illnesses. She identified that she was not overseeing staff illness to the extent she should have been. Interview on 1/28/26, at 8:45 a.m., with the HUC identified he takes the call in forms from the department heads and adds the information to the staff illness logs, he then uses the work eligibility form to identify how long staff have to stay out of work and tells staff they have to stay out 48 hours post signs and symptoms. Interview on 1/29/26 at 3:15 p.m., with the administrator and the regional administrator identified the facilities designated infection preventionist was not certified. The infection preventionist was originally contracted to be the interim director of nursing. They agreed that when she took over the infection preventionist role she should have been enrolled in an approved infection prevention certification course. In addition, they would have expected the facility infection preventionist would oversee the staff illness surveillance to ensure the safety of the resident living at the facility. Review of the facility provided Infection Prevention Surveillance policy identified its purpose is to identify possible communicable diseases or infections before they can spread to other people in the facility. Surveillance of both residents and staff is needed in the identification of possible clusters, changes in prevalent organisms, or increases in the rate of infection promptly. The results should be used to plan infection control activities, determine need for changes in current practices, identify education needs, and identify individual resident problems in need of intervention. The infection preventionist/designee will develop and maintain systems to gather surveillance data for both residents and staff, compile and analyze the data, utilize the findings to direct all Infection Prevention and Control activities within the facility, and report to the QAPI (Quality Assurance Performance Improvement) committee, monthly and as needed. When a staff member exhibits signs and symptoms of a suspected infection while at work or when they call off due to illness, the nurse or department leader made aware of the illness will:1.Refer to the Recommendations for Exclusion from Work. After illness tool and provide direction to the employee accordingly.2.Route the Colonial Manor Absence Report to the nursing department coordinator or HUC for tracking. Should the information provided indicate a potential infection, or<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | should there be additional information needed to make this determination and/or a safe return date, the HUC will make contacts with the employee as needed.3.The infection preventionist should be apprised of all staff illnesses that are potentially infectious, as must be considered when determining the facility outbreak status. A request was made for the designated Infection Preventionist certification; however, nothing was provided by the end of the survey period. |

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| Colonial Manor Nursing Home | 403 Colonial Avenue<br>Lakefield, MN 56150 |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>Based on interview and document review the facility failed to ensure the acting infection preventionist (IP) (who is the facility's interim director of nursing (IDON)) had completed specialized training in infection prevention and control. This had the potential to affect all 26 residents residing in the facility. Findings include: Review of the facility assessment identified the designated facilities infection preventionist was the IDON. Infection prevention and control program (System to prevent, identify, report, investigate, and control infections) has a system for preventing, identifying, reporting, investigating, and controlling infection and communicable disease (IPCP), for all residents, staff, volunteers, visitors and other individuals receiving services under contractual arrangements based upon the facility assessment, and following accepted national standards. Our facility uses multiple tools to control and prevent infection, including ?support from outside organizations, interactions and training with the MN department of health ICAR team, having a designated infection prevention and control officer (IPCO), bringing identified IPCP issues to the QAPI committee for root cause analysis, implementing an antibiotic stewardship program, reporting required diseases to public health authorities, has hand hygiene procedures in place, utilizes standard and transmission based precautions, screen, education and offer immunizations to residents, staff and volunteers, has a training program for residents, families, volunteers and staff, interacts with community Medical Practitioners for continuity of care. Interview on 1/28/26 at 8:24 a.m., with the IDON identified she oversees the infection control program at the facility. She stated she completed training on infection control while working in another state but was unable to provide any information or a certificate of completion of an approved infection prevention course. Interview on 1/28/26 at 2:13 p.m., with the administrator and the regional administrator identified the IDON/IP was originally hired for the director of nursing role, when the facilities infection preventionist abruptly left her employment, the IDON took on the IP responsibilities. The regional administrator was aware that the IDON was not certified for infection control. She agreed that anyone working at the facility as the infection preventionist should either be certified by an approved infection preventionist training program or be enrolled in a program to become certified as an infection preventionist. Review of the facilities infection preventionist job/MDS description identifies the IP must obtain and/or maintain a registered nurse (RN) license by the state of Minnesota and be registered with the Minnesota Board of Nursing. Must possess leadership skills, have the ability to make sound decisions, and work under pressure. Must have a thorough knowledge of federal and state guidelines, Medicare, Tardive Dyskinesia Screening, and Case Mix reimbursement or the willingness to obtain training in these areas. A high school diploma or general education development (GED), graduate of an accredited school of nursing, and experience working in a geriatric setting is preferred. The job description makes no mention that the infection preventionist shall have an IP certification or be enrolled in an IP certification program upon hire. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance for 3 of 3 residents (R3, R4, and R16). This deficient practice had the potential to affect all 26 residents who resided in the facility. Findings include: R4's 10/15/25, physician order identified the facility was to administer cefdinir 300 milligrams (MG) by mouth twice daily for 7 days for a diagnosis of a urinary tract infection (UTI). R4's October 2025, administration record identified he received cefdinir 300mg by mouth twice daily for 7 days starting on 10/15/25. R3's 10/29/25, physician order identified the facility was to administer Augmentin 875mg, twice daily for 7 days for a diagnosis of aspiration pneumonia. R3's October 2025, administration record identified he received Augmentin 875mg, twice daily for 14 days starting on 10/29/25. R16's 11/17/25, physician order identified the facility was to administer Keflex 500mg by mouth twice daily for 7 days for a diagnosis of UTI. R16's November 2025, administration record identified she was administered Keflex 500mg by mouth twice daily for 7 days starting on 11/18/25 Review of the October 2025, November 2025, infection control (IC) antibiotic stewardship log made no mention that an antibiotic time out had been completed for R4, R3, or R16. Interview on 1/28/26 at 8:24 a.m., with the infection preventionist identified they were not completing an antibiotic time out for residents who were prescribed antibiotics. Interview on 1/28/26 at 2:13 p.m., with the administrator and the [NAME] administrator identified they would have expected the infection preventionist to ensure the facility policy is followed and antibiotic time outs were completed. The facility provided Infection Control-Antibiotic Stewardship policy identified the facility may consider protocols to address improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and an antibiotic review process, also known as Antibiotic Time-Out for all antibiotics prescribed in the facility. Antibiotic Time Out's prompt clinicians to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information is available. An Antibiotic Time Out can be considered a stop order of an antibiotic when diagnostic test results or symptoms of the resident do not support the diagnosis of infection. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on interview and document review the facility failed to provide timely beneficiary notice to 1 of 3 (R31) sampled residents.Findings include: R31's last day of Medicare part A skilled services ended on 11/18/25. R31 was provided with the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) on 11/18/25 at which time R31 had signed the notice. R31 was provided with the CMS-10123 Notice of Medicare Non-Coverage on 11/18/25 at which time R31 had signed the notice. R31 was not provided with adequate time to appeal the decision and make a request for an independent reviewer authorized by Medicare to review the decision to end the services if R31 had wanted to. Interview on 1/28/26 at 3:13 p.m., with the regional administrator identified that residents were to be given 2-day notice before Medicare part A skilled services were to end. Her expectation was that the facility would provide timely notices to residents who were ending Medicare part A skilled services to ensure the resident had time to appeal the decision if they wanted to. A policy was requested but not received. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and document review the facility failed to have a discharge summary for 1 of 1 (R31) sampled residents. Findings include: R31's 12/12/25, accepted discharge Minimum Data Set (MDS) assessment identified R31's cognition was moderately impaired. R31 was independent with care, and participated in speech, occupational and physical therapy. R31 had been discharged to home/community. R31's 11/20/25, progress notes identified that R31 was excited to return to the assisted living facility. Staff reviewed the discharge summary with R31 and faxed R31's discharge orders to the pharmacy. R31's 11/21/25, progress note identified R31 discharged via private vehicle accompanied by caregiver. There was no recapitulation of R31's stay documented in the progress notes. R31's 11/21/25, Transition of Care/Discharge Summary form identified a section on the form to document a recapitulation of R31's stay which was left blank. Interview on 1/29/26 at 1:08 p.m., with director of nursing (DON) identified there was a place on the facilities Transition of Care/Discharge Summary form to document the resident's recapitulation of stay. She confirmed that the section on R31's discharge form titled recapitulation of stay had not been completed. She further revealed that there had not been a discharge summary documented for R31's stay while at the nursing home on the discharge form or in the progress notes. She was unaware that the facility needed to complete a summary of the resident's stay in addition to the discharge information provided to the accepting facility on the discharge form.A policy was requested but not provided by end of survey. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview and document review the facility failed to prevent potential accident hazards for 1 of 1 resident (R5) due to wandering behaviors into an unsecured area with steep cement stairs down to a cement floor.Findings include: R5's accepted 1/2/26, Significant change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and wandered throughout the facility including into other resident spaces. R5 had diagnoses which included: Alzheimer's disease, dementia with agitation, history of falls, and anxiety. Observation on 1/27/26 at 3:16 p.m. noted R5 wandering in her wheelchair as she went up and down each of the halls and attempted to open closed doors in the short hall across from the director of nursing (DON) office. She then turned to the right and went down the hall toward the main door and dining room area,. An unknown staff member intercepted R5 and took her to an activity that was in progress. Observation on 1/27/26 at 6:30 p.m. noted R5 transporting herself in her wheelchair down the [NAME] Hall where she attempted to enter a resident room and was redirected by staff back to the area in front of the nursing station. Observation on 1/28/26 at 10:30 a.m. noted R5 again going down the hall toward the exit door at the end of the hall, and toward the door that led to the therapy room. She was observed attempting to open doors as she proceeded down the hall.Observation on 1/28/26 at 4:30 p.m. R5 was at the end of the NW wing where she opened the door to the conference room and was attempting to enter when an unknown nursing assistant (NA) redirected her back toward the nursing station. Observation on 1/29/26 at 10:30 a.m. identified R5 pulling herself down the hall toward the hall past the DON office attempting to open doors as she proceeded. Observation on 1/29/26 at 1:45 p.m. R5 wandered down the NW hall and opened the door to the conference room, when staff redirected her back down the hall toward the nursing station. R5 had a wander guard device on her wheelchair that alarmed when she traveled close to an alarmed area. The area which extended to the right when going past the DON office had an exit door with a mural of a bookcase on the door. To the right of this door was an unsecured door that accessed the entry area for therapy. Straight ahead and to the right, was an unsecured door that allowed access to the back of the kitchen, to the left the hall went to the assisted living and to the right was a wire mesh gate, with a hook and eye closure which accessed 15 steps going to the basement. The hook and eye closure was mounted on the inside of the gate but was within reach of a person in a wheelchair and there was no resistance when the hook was lifted. The wander guard system activated when a resident got close, and sounded an alarm, but did not secure the doors. The long hall with the main entrance door on one end and the exit door with the mural at the other end, in addition to the access to the therapy were not within the line of sight of the nursing station. It was also noted if after regular business hours for therapy, management and dining, no staff would likely be in that area. There was no camera or form of monitoring identified these areas during the off hours' time periods. Interview on 1/27/26 at 10:19 a.m. with registered nurse (RN)-A identified R5 had end stage dementia, used a wheelchair for mobility, and was very active. She reported she wandered through out the facility, repeatedly going to exit doors and attempting to enter other resident spaces. RN-A identified R5 was discovered between the unsecured door that led to therapy and beside the unsecured door that allowed access to the stairway leading to the basement at least weekly. She identified R5 could open doors and did not believe the hook and eye closure on the gate at the top of the stairs would prevent her from accessing the area. Interview on 1/27/26 at 1:35 p.m. with nursing assistant (NA)- B reported R5 wandered throughout the facility and did go to exit doors and attempted to enter other resident spaces. NA-B identified R5 had a Wander Guard device and staff responded quickly when it sounded as it was frequently R5 setting off the alarm. She also reported R5 had been found in the area between the unsecured door and the therapy door, but she was not certain how often it occurred, but reported it was at least weekly. Observation and interview on 1/28/26 at 1:45 p.m. with the maintenance supervisor, administrator, and regional director of<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | skilled operations of the area near the exit door, unsecured door entering the hall leading to the therapy room and the unsecured door to the hall accessing kitchen, basement stairs, and the assisted living area. They confirmed there was no locking or security measure in place for the identified areas. They confirmed when the renovation was recently completed the potential for access by unauthorized persons had not been identified and presented a potential hazard if a wandering resident were to access the area before staff were able to respond to the sounding alarm. Review of the February 2017 policy Elopement identified it was the responsibility of all staff to assist in investigation of a reported missing resident,. The policy failed to include any reference to monitoring a resident who attempted to access unauthorized areas, or response to residents utilizing a wander guard device and attempting to access alarmed exits or restricted areas. No additional policies or procedures were provided during the survey period. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation, interview and document review the facility failed to include the facility census in their daily posting of nursing staff for 29 of 29 days reviewed.Findings include: Observation on 1/27/26 at 6:52 a.m., in the front entry of the building prior to entering the main door of the facility was a daily staff posting hanging up on the bulletin board titled Colonial Manor Nursing Home. The form included the facility name, a place to document the date, the census, and a list of positions for each shift. The form was dated 1/27/26 and the positions for each shift were circled with a total number of hours for that position for that shift. The census section of the form was blank. Interview on 1/27/26 at 6:55 a.m., with registered nurse (RN)-A who was working as the charge nurse upon entry to the facility was unaware of the current facility census and she asked the trained medication aid (TMA)-A working on the medication cart if she knew the census. The TMA-A reported she was not sure and then proceeded to look up in the facility electronic record and reported that the facility census was currently 26. Observation on 1/28/26 at 2:53 p.m., of the Colonial Manor Nursing Home daily staffing posting identified there was no facility census documented on the form. Observation on 1/29/26 at 12:24 p.m., of the Colonial Manor Nursing Home daily staffing posting identified there was no facility census documented on the form. Interview on 1/29/26 at 3:00 p.m., with the business office manager identified that the night nurse filled out the daily staffing posting form. The form was to include the facility current census. Review of the daily staff postings from 1/1/26 through 1/29/26 revealed that the census section had been left blank on each day. Review of the undated Nurse Staffing Information and Daily Census policy identified that the facility must post daily the following information: the facility name, current date, total number and actual hours worked by title and license, and the resident census. The posting must be placed in a prominent place and be easy to read. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 2 of 5 sampled residents (R6, and R14) were offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC).Findings include: Review of the current Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV 21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV 21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV 21) at any age and a PPSV23 at or after the age of [AGE] years old. R6's 8/18/25 comprehensive Minimum Data Set (MDS) assessment identified he was [AGE] years old. He had diagnosis of renal failure, thyroid disorder, and dementia. Section O-Special Treatments and Programs identified R6's pneumococcal vaccinations were not up to date, and the facility did not offer him pneumococcal vaccinations while he was a resident at the facility. R6's current immunization report provided by the facility identified he received a pneumo-PPSV23 on 1/4/11 and a Pneumo-PCV13 on 3/19/15. R6's medical record had no indication that the facility had offered to administer a PCV20 or PCV21 upon admission or during his stay. R14's 12/16/25, quarterly Minimum Data Set (MDS) assessment identified she was [AGE] years old. She has a diagnosis of anemia, renal failure, and diabetes mellitus. Section O-Special Treatments and Programs identified R14's pneumococcal vaccinations were up to date. R14's current immunization report provided by the facility identified she received a pneumo-PPSV23 on 7/8/11, and a Pneumo-PCV13 on 1/20/16. R14's medical record had no indication that the facility had offered to administer a PCV20 or PCV21 upon admission or during her stay. Interview on 1/2/26 at 8:24 a.m., with the designated infection preventionist identified she was not aware that the residents mentioned above were eligible to receive additional vaccinations per the CDC guidance. Review of the facility provided Vaccination Policy identified the facility would offer all residents vaccinations per the Centers for Disease Control (CDC) recommendations. The RN Case Manager and Infection control Coordinator would be responsible for researching resident medical records and history to determine if the vaccinations have been given. |