STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285183	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Randolph	811 South Main Street Randolph, NE 68771

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 29638 Licensure Reference Number 175 NAC 12-006.05(B) Based on record review and interview, the facility failed to provide Resident 36 and/or the resident's representative, bed hold information when the resident was transferred to the hospital. The sample size was 1 and the facility census was 38. Findings are: A. A record review of the facility's Bed Hold policy (revision date of 12/23) revealed the facility was to provide written information to the resident and/or the resident representative regarding the right to exercise the bed hold provision of 15 days at admission and then provide an additional notice before transferring to a general acute care hospital or before the resident went on a therapeutic leave. In the event of an emergency transfer, the additional notice was to be provided within 24 hours. The written information to be given to the resident and/or representative included the following: -The duration of the state bed-hold, if any, during which the resident was permitted to return and resume residence in the facility. -The reserve bed payment policy in the state plan if any. -The facility policy regarding bed-hold periods to include permitting residents to return to the next available bed. -Conditions upon which the resident would be able return to the facility. B. A record review of Resident 36's nursing progress notes revealed the following: -9/10/2024 at 3:39 AM the resident reported to the direct care staff that something was wrong and wanted the nurse. Upon assessment, the resident had an irregular respiratory rate and pulse with complaints of difficulty breathing. The resident requested to be evaluated in the emergency room . -9/10/2024 at 7:15 AM the facility received notification the resident was admitted to the hospital. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9/12/24 at 1:45 PM the facility received notification the resident was to be discharged from the hospital and was to return to the facility. A record review of Resident 36's medical record from 9/10/24 to 9/12/24 revealed no evidence the resident or the resident's representative were notified of the facility bed hold policy. During an interview on 10/02/24 at 10:19 AM, the Administrator confirmed the facility had no documented evidence that Resident 36 or their representative were provided with the required bed hold information when discharged to the hospital from 9/10/24 to 9/12/24.

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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** 42360 Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on interview and record review; the facility failed to ensure Resident 30's Care Plan was revised to address suicidal ideation and failed to include mood and behavior interventions in the Care Plan for Resident 35. The sample size was 15 and the facility census was 38. Findings are: A. Review of the facility's undated Care Plan policy revealed that care plans were modified between care conferences and when appropriate to the resident's current needs, problems, and goals. This included: -A significant change in the resident's condition, -a change of planned interventions, -new goals were established, -new diagnosis, medication, or abnormal labs, and -revisions that involved the care of other disciplines were done through consultative and collaborative efforts and documented. B. Review of Resident 30's Minimum Data Set (MDS, federally mandated comprehensive assessment tool used to develop resident care plans) dated 9/6/24 revealed the resident had intact cognitive functioning, had complex medical conditions including hemiplegia (partial or complete paralysis on one side of the body), diabetes, hypertension, and vascular (blood circulation) disease. The resident was mildly depressed, always felt socially isolated and had chronic pain. In addition, the resident was dependent for bathing, toileting hygiene, and bed mobility, and received substantial assistance with dressing. A record review of Resident 30's Care Plan with a revision date of 7/14/24 revealed the resident had chronic pain and used antidepressant medication. There was no indication the Care Plan addressed the resident's comments of self-harm or include interventions related to the residents comments of self-harm. A record review of Resident 30's progress notes revealed the following: -On 9/21/24 at 9:48 PM The resident had requested arsenic or cyanide to get this over with. In addition, the resident requested a knife and stated, All I need is a butter knife through my skull. The nurse implemented 15-to-30-minute checks and notified the Director of Nursing (DON). The DON directed the staff to use plastic silverware and notify the physician. (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 10/03/24 at 9:21 AM the DON confirmed that Resident 30's Care Plan did not address the Resident's suicidal ideation, or the interventions put in place for the resident's safety (15-to-30 minute checks and plastic silverware). 45739 C. A record review of Resident 35's MDS dated [DATE] revealed the resident was cognitively intact, had diagnoses of depression, spine narrowing, heart disease and stroke, and the mood assessment indicated the resident had felt down, depressed or hopeless nearly every day; had trouble falling or staying asleep, or was sleeping too much nearly every day; felt tired or had little energy nearly every day; felt bad about themselves or that they were a failure or let their family down nearly every day; had thoughts that they were better off dead, or of hurting themselves in some way nearly every day, the resident had pain almost constantly rated 9 out of 10, had limited range of motion, and was dependent with toileting, lower body dressing and required maximal assistance with upper body dressing, and hygiene. A record review of Resident 35's Care Plan last revised 9/3/24 revealed the resident required assistance with hygiene, dressing, transfers, and toileting; had a history of a stroke; had depression with interventions to encourage to express feelings, monitor/document/report signs or symptoms of depression and provide the resident gaming time. There was no documentation to show the facility addressed the resident had thoughts they were better off dead, or of hurting themselves. A record review of the facility facsimile form Physician Fax regarding Resident 35 dated 5/21/24 revealed the resident was interviewed and revealed they had no plan of hurting themselves. The facility had interventions to increase staff 1:1 to four times per week, encourage the resident to go outside daily for 15-20 minutes, and continue to encourage the resident to go to the dining room for meals. Interview on 10/3/24 at 11:20 AM with the DON confirmed Resident 35's Care Plan did not address Resident 35's thoughts that they were better off dead or of hurting themselves. Further interview confirmed the interventions indicated on the fax were not implemented onto the Care Plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09(H) Based on observations, record review and interview; the facility staff failed to identify and/or monitor bruising and to evaluate causal factors related to the bruise for 1 (Resident 17) of 1 sampled resident. The facility identified a census of 38. Findings are: A record review of Resident 17's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 9/19/24 revealed the resident was admitted on [DATE] with diagnoses of stroke, hemiplegia (weakness or partial paralysis of 1 side of the body) and anemia. The facility staff assessed the following about the resident: -Severe cognitive impairment. -Substantial to maximal assistance required with bathing/showering, dressing, personal hygiene, bed mobility and transfers. -Always incontinent of bladder and frequently involuntary of bowel. A record review of Resident 17's current Care Plan (undated) revealed the resident was at risk for impairment to the resident's skin. Interventions included: -Monitor/document/report to the physician any changes in skin status, appearance, color, wound healing, signs of infection and wound size. -Weekly head to toe skin assessment. -Notify the Charge Nurse immediately of any new areas of skin breakdown; redness, bruising, blisters, and any discoloration noted with the resident's bath or with cares. -Encourage to turn and reposition and provide assist, as necessary. Observations of Resident 17 on 9/30/24 at 2:51 PM, and on 10/1/24 at 6:45 AM revealed the resident had a large bruise to the top of the resident's left hand. The bruise was yellow/green in appearance and completely covered the dorsal aspect of the resident's left hand. A record review of Weekly Skin Evaluations conducted on 9/24/24 at 8:27 PM and on 9/30/24 at 11:30 PM revealed documentation which indicated Resident 17 had no new skin issues noted. During an interview on 10/1/24 at 7:00 PM, Nurse Aide (NA)-B confirmed the bruising to the top of the resident's left hand was at least 1 week old. NA-B stated they had reported the bruise to the Charge Nurse a week ago when NA-B gave the resident a bath. NA-B was uncertain as to how the bruising had occurred. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 17's medical record which included Treatment Administration Records (TAR), Nursing Progress Notes, and Weekly Skin Evaluations revealed the bruising to the resident's left hand had not been identified and was not being monitored to ensure healing. In addition, there was no evidence the staff had evaluated causal factors to determine how the bruising had occurred. During an interview on 10/1/24 at 10:20 AM, Registered Nurse (RN)- I confirmed staff were to complete weekly skin evaluations on each resident to identify any new areas of skin breakdown and then were to continue to monitor/assess the areas weekly until resolved. RN-I indicated no knowledge regarding the bruising to Resident 17's left hand.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45739 Licensure Reference Number 175 NAC 12-006.09 Based on interview and record review; the facility failed to ensure Resident 18's antianxiety medication had a duration for use/stop-date. The sample size was 5 and the facility census was 38. Findings are: Review of the facility's Psychotropic Medication policy with a revision date of 12/2023 revealed the following: -The facility ensured residents who had not used psychotropic (drug that affects how the brain works and causes changes in mood, awareness, thoughts, feeling, or behavior) drugs were not given those drugs, unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record, -Residents who used psychotropic drugs received gradual dose reductions and or behavioral interventions unless clinically contraindicated, -Psychotropic medications were not administered for the purpose of discipline or convenience and only administered when required to treat the resident's medical symptoms after nonpharmacological interventions had been attempted and failed, and -as needed (PRN) orders for psychotropic medications were limited to 14 days, and in order for psychotropic medication orders to be extended beyond 14 days, the provider documented the rationale and duration for the order. Review of Resident 18's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 9/6/24 revealed the resident had severe cognitive impairment, had diagnoses of cancer, seizures, anxiety, depression, and a psychotic disorder; and was dependent in oral hygiene, toileting, dressing, and transfers. Review of Resident 18's Care Plan last revised 9/20/24 revealed the resident was at risk for seizures, was receiving hospice services, had severe cognitive impairment, required assistance with transfers, toileting, bed mobility, and dressing, and had anxiety with behaviors. Review of Resident 18's Medication Administration Records (MAR) for August and September 2024 revealed an order for Lorazepam (antianxiety medication) Concentrate every 6 hours PRN (as needed) for anxiety, shortness of breath, restlessness, or seizure activity. This order was started on 8/14/24 with no documented stop date or duration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility form Medical Doctor (MD)/Nursing Communications dated 8/14/24 revealed an order for Lorazepam liquid for seizure activity every 6 hours PRN with no stop date or duration documented. Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 10/3/24 at 9:50 AM confirmed as needed Lorazepam should have a stop date documented. Further interview with the DON on 10/3/24 at 11:20 AM confirmed Resident 18's as needed Lorazepam did not have a stop date documented.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 29638 Licensure Reference Number 175 NAC 12-006.10(D) Based on observations record review and interviews; the facility failed to ensure a medication error rate of less than 5%. Observations of 31 medications revealed 2 errors resulting in an error rate of 6.45%. The errors effected 2 (Resident 25 and 21) of 3 residents. The facility census was 38. Findings are: A. Review of the facility policy Administering Medications with a review date of 5/21 revealed the following: -Medications must be administered in accordance with the orders, including any required times. -Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). -The individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time, and right route before giving the medication. B. Review of the undated manufacturer's instructions for administration of an insulin pen revealed the following procedure should be completed: -To avoid air being injected and ensure the proper dose is administered, turn the dose selector to select 2 units. -Hold the insulin pen with the needle pointing up. Tap the cartridge gently with finger a few times to make any air bubbles collect at the top. -Keep the needle pointing upwards, press the push-button all the way in until the dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat. Ensure the dose selector is set at zero after air is expelled. -Turn the dose selector to the number of units you need to inject and insert the needle into the skin. -Inject the dose by pressing the push button all the way in until the dose selector returns to zero. C. Review of Resident 25's physician orders revealed an order dated 8/7/25 for Insulin Glargine (medication used to treat diabetes) 15 units subcutaneously (applied under the skin) twice a day. Observation on 10/1/24 at 9:38 AM of Licensed Practical Nurse (LPN)-A preparing to administer Resident 25's Insulin Glargine 15 units subcutaneously per an insulin pen: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN-A held the pen sideways, then turned the dose selector to 15 units. -LPN-A injected the insulin into the resident's skin until the dose selector returned to zero. Interview with LPN-A on 10/1/24 at 10:00 AM confirmed the LPN failed to prepare the Glargine Insulin pen by expelling 2 units of potential air bubbles prior to selecting the ordered dose of insulin to prevent a medication error. D. Review of Resident 21's physician orders revealed an order dated 3/3/23 for Pantoprazole (medication used to treat heartburn and acid reflux) 20 milligrams daily. Review of Resident 21's medication label for Pantoprazole 20 milligrams revealed the medication was to be administered daily. In addition, the medication label indicated it was to be given 30 to 60 minutes before the meal. Observation of Registered Nurse (RN)-I preparing medications for Resident 21 on 10/2/24 at 8:01 AM, revealed RN-I administered Resident 21's Pantoprazole 20 milligrams. The resident was seated at the dining room table and was served their breakfast meal at 8:10 AM (9 minutes after the resident's Pantoprazole was administered). During an interview on 10/3/24 at 8:42 AM, RN-I confirmed Resident 21's Pantoprazole 20 mg was to be given 30-60 minutes before the resident was served their meal and had not been administered as ordered by the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51391 Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, record review, and interview; the facility failed to store foods to prevent the potential for food borne illness and assure food safety as staff and/or resident food items were stored in a resident refrigerator without a label and date; This had the potential to affect all residents that ate from the facility kitchen. The facility census was 38. Findings Are: Review of the Nebraska Food Code based on the United States Food and Drug Administration Food Code and used as an authoritative reference for food service and sanitation practices revealed the following: -2-401.11(A) an employee shall eat, drink . in designated areas where the contamination of exposed food; clean equipment, utensils, and linens; unwrapped single-service and single-use articles; or other items needing protection cannot result. -3-201.11(C) Packaged Food shall be labeled as specified by law, including 21 CFR 101 Food labeling, 9 CFR 317 Labeling, Marking Devices, and Containers and 9 CFR 381 Subpart Labeling and Containers. -3-501.17 of the Food Code, refrigerated, ready to eat, time/temperature control for safety food prepared and held in a food establishment for more than twenty-four hours shall be clearly marked to indicate the date of preparation. Observation conducted during the initial kitchen tour on 9/30/24 at 10:34 AM with Dietary Aide (DA)-G, revealed the following items in the resident refrigerator which were stored without a label and/or a date and without identification as to which resident the items belonged to: -A juice-like drink in a 24-ounce clear plastic container. -2 containers with tomatoes. -A sandwich in plastic wrap. -A container with peppers, onions, chicken legs and squash. During an interview on 10/2/24 at 3:00 PM, the facility Operations Manager confirmed items stored in the kitchen refrigerators should be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45739 Licensure Reference Number NAC 175 12-006.18 Based on observation and interview; the facility failed to wear Personal Protective Equipment (PPE) as required to prevent the potential spread of infection, failed to store Resident 30's urinal to prevent the potential for cross contamination, failed to store oxygen equipment for Resident 34 to prevent the potential for cross contamination, and failed to change gloves and wash hands at the required intervals during the provision of incontinence cares for Resident 23. The total sample size was 17 and the facility census was 38. Findings are: A. Review of the facility policy Infection Control, last revised 10/22 revealed the following: -The elements of infection prevention and control program consisted of oversight, surveillance, data analysis, outbreak management, and prevention of infection, -The goals were to to decrease the risk of infections, identify and correct problems related to infection control, ensure compliance, and monitor personnel health and safety, -Under the infection control program, the facility would decide what measures would be applied in individual circumstances, and -The facility staff would conduct themselves and provide care in a way that would minimize the spread of infections. B. The following observations were made: -On 9/30/24 at 10:15 AM upon entering the facility a sign out front that read the staff were to be wearing masks and eye protection, -On 10/2/24 at 7:30 AM Registered Nurse (RN)-H was talking to a visitor in the facility and their mask was below their nose, -On 10/2/24 at 9:22 AM RN-H was observed pushing a resident in a wheelchair, RN-H stopped to talk to the resident and their mask was below their nose, -On 10/2/24 at 2:10 PM RN-H came out of a resident's room with their mask below their nose and their eye protection on top of their head, -On 10/3/34 at 8:10 AM RN-H was walking through the dining room (residents were eating breakfast) and their mask was below their nose, and -On 10/3/24 at 8:50 AM RN-H was in the dining room assisting a resident to eat their breakfast and the RN's mask was below their nose. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/3/24 at 9:30 AM with the Infection Preventionist confirmed masks were to be worn covering the nose and the mouth. An interview on 10/3/24 at 9:35 AM with the Director of Nursing (DON) confirmed RN-H was not wearing their mask correctly. 51391 C. Review of the facility policy Respiratory Equipment Cleaning & Storage with a revision date of 2/2019 revealed the following: -It was the policy of the facility to maintain respiratory therapy equipment in a clean and sanitary manner and to use tubing, masks, and cannulas (the nasal cannula end of the tubing fits into your nose and is the most common delivery accessory) for residents receiving therapy. -When licensed staff removed treatment, the tubing would be covered or stored in a bag. D. Review of the facility's Hand Hygiene Infection Control Policy with a revision date 10/2022 revealed the following: -It was the policy of the facility to provide the necessary supplies, education, and oversight to ensure healthcare workers performed hand hygiene based on accepted standards. -All personnel followed the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. -Use of an Alcohol-Based Hand Rub (ABHR), containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -before moving from a contaminated body site to a clean body site during resident care, -after contact with a resident's intact skin, -after contact with blood or bodily fluids, and -after removing gloves. E. The following observations of Resident 34's oxygen equipment from 9/30/24 through 10/2/24 revealed the following: -On 9/30/24 at 3:36 PM the oxygen tubing and nasal cannula (a device that delivers extra oxygen through a tube and into the nose) laid on the floor with no date on the tubing and no storage bag on the concentrator (takes air from your surroundings, extracts oxygen and filters the oxygen into purified oxygen for breathing). -On 10/1/24 at 7:55 AM the oxygen tubing and nasal cannula laid on the floor with no date on the tubing and no storage bag on the concentrator. -On 10/2/24 at 7:36 AM the oxygen tubing was hung over the side of the oxygen concentrator, and the oxygen cannula touched the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 7:55 AM, Certified Nursing Assistant (CNA)-L confirmed Resident 34 wore oxygen at night, took the oxygen tubing off in the morning, staff shut the oxygen concentrator off and put the tubing in a white bag. CNA-L confirmed that there was no white bag on the side of the concentrator. An interview on 10/1/24 at 9:16 AM with Licensed Practical Nurse (LPN)-J confirmed that Resident 34 wore oxygen at night, took the oxygen tubing off, handed the tubing to staff or laid it on the resident lap, staff shut oxygen concentrator off and put the tubing in a white mesh bag. An interview on 10/2/24 at 7:36 AM with Resident 34 confirmed taking the oxygen tubing off and I either hand it to the staff or lay it on my lap. An interview on 10/2/24 at 10:30 AM with the DON, confirmed that the oxygen tubing with the nasal cannula should be stored in a bag on the side of the concentrator when not in use. F. During an observation of care for Resident 23 on 10/2/24 at 7:52 AM, CNA-B put gloves on, assisted the resident with sitting up on the edge of bed, dressing and hygiene. CNA-B transferred the resident with a mechanical stand-up lift, removed an incontinent brief (was wet), completed perineal cares (washing the genital and rectal areas of the body), put on a clean brief, pulled up the resident pants, transferred resident into wheelchair and then removed the gloves that had been worn throughout all cares provided. CNA-B made the resident's bed, straightened up the room and took out the trash and dirty linens. All tasks were completed without the benefit of hand hygiene. An interview on 10/2/24 at 2:45 PM with the DON confirmed that hand hygiene should be completed when staff enter a resident room, after gloves are removed from hands, when going from a dirty to a clean task, and before exiting the resident room. 42360 G. Review of Resident 30's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to develop resident care plans) dated 9/6/24 revealed the resident had intact cognitive functioning, had complex medical conditions including hemiplegia (partial or complete paralysis on one side of the body), diabetes, and hypertension and vascular (blood circulation) disease. The resident was mildly depressed, always felt socially isolated and had chronic pain. In addition, the resident was dependent for bathing, toileting hygiene, and bed mobility, and received substantial assistance with dressing. Review of Resident 30's Care Plan with a revision date of 7/14/24 revealed the resident was dependent on staff for cares, had a history of a stroke with hemiplegia (partial or complete paralysis on one side of the body), required the assistance of 1-2 staff to turn side to side in bed, was dependent for transfers using a mechanical lift, was dependent for dressing, and dependent for toileting hygiene. During observations of Resident 30 from 9/30/24 through 10/3/24 the following was identified: -On 9/30/24 at 1:35 PM the resident was lying in bed, and a tray of food was present on the overbed table. There were also several cans of chips on another overbed table next to the resident. There was also a urinal with a small amount of urine in it sitting on the overbed table near the snacks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285183	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Randolph	811 South Main Street Randolph, NE 68771

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/30/24 at 3:25 PM the resident was lying in bed and there was an empty urinal on overbed table next to the resident's snacks. -On 10/1/24 at 6:50 AM the resident was lying in bed and a urinal was on the overbed table next to snacks. -On 10/1/24 at 9:10 AM the resident was sitting up in the bed talking on the telephone and a urinal was sitting on the bedside table beside a food tray. -On 10/2/24 at 7:01 AM the resident was lying in bed and a urinal was sitting on the overbed table next to a water pitcher and box of crackers. -On 10/3/24 at 7:45 AM the resident was lying in bed and the urinal was on the overbed table next to the water pitcher. During an interview on 10/2/24 at 10:30 AM RN-R confirmed that allowing Resident 30's urinal to be stored/kept on the overbed table next to the residents' water pitcher, food or snacks was not in line with the facility infection control practices.