STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Amana	**3207 220th Trail , Amana, Iowa, 52203**

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F0000	INITIAL COMMENTS Correction Date:_____ The following deficiencies relate to the facility's annual health survey completed 7/20/26 to 7/22/26. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, facility documentation, and policy review the facility failed to store, prepare, and distribute food under sanitary conditions during 3 of 3 observations. The facility failed to ensure expired foods were discarded,	F0812		

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 reverse for further 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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F0812 SS = F	Continued from page 1 maintain clean work spaces, and manage pest control. The facility reported a census of 43 residents. Findings include: On 7/20/26 at 8:59 AM an observation of the kitchen showed the following: 1 reduced calorie cream cheese icing and 1 reduced calorie butter vanilla icing expired 5/5/26. 6 containers of bread crumbs expired 6/2/26. Onion skins and white food debris lay on the floor of the walk-in cooler, under the pie filling storage shelf, and on the floor of the dry storage area. A dead cricket and two dead flies lay behind a bug trap next to the storage shelf. Flies landed on the surface of a silver and black cart, on a spatula used to make an omelet, on the hood above the cooking omelet, on the coffee machine, and on food preparation surfaces. The floor felt sticky with food debris noted throughout the kitchen. A two foot by 6 inch section of the floor near the coffee machine contained a yellow powdery substance, with a small area matted into the grout (mortar between tiles) and some tracked towards the cooktop about 5 feet away. Additional white and brown food debris scattered from the same area through the kitchen to the service window about 10-15 feet away. A tater tot and additional food debris lay under the counter drawers near the dishwashing area, which didn't match the food served for breakfast. Water tracked from the dish machine area to the kitchen, making some food debris on the floor pasty. The convection (hot air circulating) oven contained food debris inside where the bottom met the side, and a yellow/brown substance on the door and base of the oven felt sticky to the touch and contained additional food particles. On 7/21/26 at 10:50 AM an observation of the kitchen showed the expired items remained, dry storage and walk-in cooler floors contained food debris and onion skins, dead bugs remained on the floor, and food debris sat pushed against baseboards (molding along bottom of walls) under countertops and sinks. The debris felt dried and hard to the touch. The floor continued feeling sticky	F0812		

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F0812 SS = F	Continued from page 2 in areas, and the section of yellow powdery substance turned pasty and stuck into grout. The tater tot and food debris remained under counter drawers, and a cube of cheese sat under the counter with the toaster. The July 2026 cleaning schedule documented the following missed weekly cleaning tasks: sweep walk in fridge and freezer, weeks 1 and 2 dessert cart, week 2 cart, weeks 1 and 2 grill and stove top, weeks 1 and 2 toaster, weeks 1 and 2 floor behind the dish room, weeks 1 and 2 walls behind the dish room garbage, week 2 metal table under the toaster, weeks 1 and 2 On 7/22/26 at 1:23 PM Staff E, Cook, stated staff needed to follow the cleaning schedule. Staff E stated assigned weekly and monthly tasks included the cooler and dry storage areas. Staff E stated staff needed to mop the floor after lunch shift and evening shift. Staff E acknowledged a lot of fly activity in the kitchen and dining room and stated staff tried to close doors better. Staff E indicated residents used the dining room door handicapped button to hold the door open, which had an impact. Staff E expected staff to throw out expired food upon seeing it. On 7/22/26 at 1:31 PM Staff F, Certified Dietary Manager (CDM), reported sometimes having to cover items on the cleaning schedule if Staff F saw tasks didn't get completed. Staff F stated staff needed many reminders, and staff recently discussed mopping. Staff F expected dietary aides and cooks to sweep and mop before leaving for the day, noting staff needed to complete mopping every shift no matter what. Staff F acknowledged the tater tot remained there since at least Sunday. Staff F felt fly activity grew much worse over the past two weeks and didn't know why bug lights in the dining room didn't help. Staff F didn't know expired items existed in dry storage.	F0812		

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F0812 SS = F	Continued from page 3 On 7/22/26 at 1:44 PM during an observation of the kitchen with Staff F, the expired items remained in the storage area. Bugs remained on the floor, and webs and food debris sat under the bins of the pie filling shelf in dry storage. Staff F confirmed this formed part of the cleaning schedule. Staff F stated having just cleaned the convection oven and noted the sticky substance still present felt like tape. Staff E completed mopping during the observation. Further observation of the area with the yellow substance showed some pasty yellow substance remained matted to grout, and food particles continued lining baseboards between counters and under sinks. The tater tot from Monday and cheese cube from Tuesday remained. A record review of an email from Staff G, Administrator, dated 7/22/26 at 1:34 PM showed the facility didn't have a kitchen cleaning policy.	F0812		
F0908 SS = F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, facility record review, and manufacturer instructions, the facility failed to properly maintain the commercial laundry equipment and ensure staff performed the required maintenance to prevent lint accumulation and fire hazards for 1 of 2 laundry dryers (Dryer 1) used for all the resident's laundry in the facility. The facility reported a census of 43 residents. Findings include: On 7/21/26 at 10:45 AM Staff A, Laundry Supervisor, showed dark grey insulation material mixed with lint on the side of Dryer 1 in the laundry room. Staff A removed a basketball-sized pile of lint and insulation material from Dryer 1 and stated Dryer 1 had 12 years of use and represented the worst unit. Staff A demonstrated particles falling off the insulation into the compartment below Dryer 1 where the lint trap sits. Staff A stated all laundry staff and maintenance knew about the issue and staff contacted a laundry machine servicing company several years prior, but Staff A couldn't provide proof of the conversation. Staff A further stated staff clean the lint trap every two loads, clean	F0908		

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F0908 SS = F	Continued from page 4 better at the end of the night, clean the side once a day, and vacuum underneath the lint trap once a month. Staff A stated the facility didn't have a cleaning log or a formal cleaning policy. On 7/21/26 at 11:22 AM Staff B, Maintenance Director, stated during an interview being unaware of current equipment issues and laundry staff hadn't informed Staff B of dryer issues. Upon learning about Dryer 1's condition, Staff B stated being unaware of the issue and requested to inspect Dryer 1. On 7/21/26 at 11:25 AM Staff B inspected the laundry room with Staff A and observed dangling insulation on the right-hand side of Dryer 1 measuring approximately one foot long and over one inch thick. Staff A reiterated calling the laundry machine servicing company several years ago and stated the insulation pulls off in large chunks. Staff B confirmed this represented the first-time staff made Staff B aware of the issue. Staff B instructed Staff A to clean out Dryer 1 and remove Dryer 1 from service due to lint trapped in the insulation creating a fire safety issue. On 7/22/26 at 9:44 AM an email sent to Staff C, Administrator, requested the laundry operator's manual and the laundry cleaning schedule. A record review of an email received from Staff C on 7/22/26 at 10:27 AM showed a statement staff cleans out the dryer lint area daily per recommendations on the front of the lint compartment. The facility failed to provide cleaning logs or a formal policy demonstrating staff performed cleaning. The Operator's Manual for DTCH55 Series Dryers received from Staff C on 7/22/26 at 10:14 AM instructed under Preventive Maintenance to clean the lint screen daily and remove lint accumulation from the lint screen compartment, front control compartment, exhaust system (venting mechanism), and areas above, below, and around the burners (heating components) to prevent a buildup of lint creating a fire hazard.	F0908		

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F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, observation, resident interview, staff interview, and facility policy review, the facility failed to keep call lights within reach for 2 of 3 residents reviewed for accommodation of needs (Residents #27, #20, and #7). The facility reported a census of 43 residents. Findings include: 1. Resident #27's Minimum Data Set (MDS) quarterly review assessment dated 7/8/26 documented a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. Resident #27 required limited physical assistance of 1 person for toileting, dressing, and personal hygiene. Resident #27's Care Plan revised 7/9/26 identified a self-care deficit. The Care Plan instructed staff to assist Resident #27 with toileting and activities of daily living (ADLs), noting Resident #27 calls for assistance to use the bathroom. On 7/20/26 at 9:54 AM observed Resident #27 sitting in her room with the call light placed under her pillow, away from Resident #27 and out of reach. On 7/20/26 at 9:54 AM Resident #27 stated she had to holler for help or ask her roommate to signal staff when unable to reach her call light because she couldn't get up on her own. Resident #27 stated the call light being out of reach occurs at least once a week, causing stress and leaving her stuck waiting over an hour for help when her roommate isn't around. 2. Resident #20's MDS annual assessment dated 7/15/26 documented a BIMS score of 14, indicating intact cognition. On 7/20/26 at 10:02 AM Resident #20 stated she	F0558		

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F0558 SS = D	Continued from page 6 helped her roommate (Resident #27) get ahold of staff when Resident #27's call light isn't in reach. Resident #20 stated this occurs at least once a week. 3. Resident #7's MDS comprehensive assessment dated 6/21/26 documented a BIMS score of 6, indicating severely impaired cognition. Resident #7's MDS documented diagnoses including dementia (memory loss) and recorded Resident #7 experienced a fall since the prior assessment. Resident #7's Care Plan revised 6/22/26 identified a potential for trauma and falls related to orthostatic hypotension (low blood pressure upon standing), vertigo (dizziness), and a history of falling. The Care Plan instructed staff to keep personal items and frequently used items within reach. On 7/21/26 at 10:22 AM witnessed Resident #7 sitting in her recliner. The call light laid in the middle of the bed, out of reach for Resident #7. When asked if she could reach the call light, Resident #7 attempted to stretch her arm over to the bed, but couldn't reach it. On 7/21/26 at 12:20 PM Staff C, Certified Nurse Aide (CNA), stated everyone should have their call light next to them when in their room. On 7/21/26 at 12:35 PM Staff D, Director of Nursing (DON), stated no resident should go without a call light. Staff D stated they expected the staff to make sure the call light was in reach whenever in a resident's room or when a resident laid in bed, they should move the call light near the resident before leaving the room. On 7/22/26 at 2:20 PM Staff E, Administrator, stated the facility didn't have a call light policy.	F0558		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of	F0644		

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F0644 SS = D	Continued from page 7 this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure staff submitted an updated Preadmission Screening and Resident Review (PASRR) when 1 of 1 resident reviewed experienced a change in mental health diagnosis and medication (Resident #8). The facility reported a census of 43 residents. Findings include: A Preadmission Screening and Resident Review (PASRR) dated 11/18/24 indicated Resident #8 had diagnoses of anxiety (excessive worry) and depression (mood disorder). Resident #8 took fluoxetine (antidepressant medication) for depression and trazodone (sleep aid medication) for depression at time of assessment. A Care Plan problem dated 4/17/26 documented Resident #8 had potential for alteration in thought processes related to psychotropic (mind-altering) medication use. Another Care Plan problem dated 4/17/26 indicated potential for ineffective individual coping related to delusions (false beliefs). Resident #8's Medication Administration Record (MAR) dated July 2026 documented the following medications: Fluoxetine HCL 40 mg for depression Mirtazapine 15 mg for depression Quetiapine fumarate 25 mg for psychosis (loss of contact with reality)	F0644		

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F0644 SS = D	Continued from page 8 Resident #8's Minimum Data Set (MDS) dated 7/8/26 documented current diagnoses of anxiety disorder, depression, and psychotic disorder. Section N showed Resident #8 took antipsychotic and antidepressant medications on a routine basis. On 7/22/26 at 2:06 PM Staff A, Administrator, stated the social worker maintained responsibility for completing the PASRR when a resident's mental health diagnoses changed. On 7/22/26 at 2:26 PM Staff D, Social Worker, stated receiving session notes from the psychiatric nurse practitioner and informing the MDS coordinator if a change in diagnosis or medication occurred. Staff D stated evaluating new mental health diagnoses or medications to decide if a new PASRR requirement existed, needing to review Resident #8's records to check when psychotic disorder appeared. During a follow-up interview on 7/22/26 at 2:46 PM Staff D stated Resident #8 received the diagnosis of psychosis March 2025 and started quetiapine March 2025. Staff D confirmed Resident #8 didn't have a diagnosis of dementia (memory loss) at the time and didn't complete a PASRR with the psychosis diagnosis and medication change. Staff D stated submitting a PASRR probably represented a good idea, didn't know if the update would've triggered a Level II PASRR, but couldn't know for sure and should've submitted the form. The PASRR Provider Manual dated 2/19/25 instructed nursing the facility staff to contact PASRR to report changes whenever a nursing facility resident with mental illness experienced changes that could affect their placement or service decisions.	F0644		