STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ KG	INITIAL COMMENTS Correction date: 8/23/25 The following deficiencies resulted from the facility's annual recertification survey conducted on July 21, 2025 to July 24, 2025. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F0578		

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
[signature]	Administrator	8/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0578 SS = D	Continued from page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure accurate resident code status (resident decision to have cardiopulmonary resuscitation (CPR) performed or do not resuscitate (DNR) in the event of cardiac arrest) information recorded and readily available for 1 of 16 residents (Resident #24) reviewed for code status. The facility reported a census of 30 residents. The Minimum Data Set (MDS) assessment for Resident #17, dated 6/15/25, identified the resident had a diagnoses of cerebral vascular accident and dementia, and a Brief Interview for Mental Status score of 11 out of 15 (indicative of moderate mental impairment). On 7/21/25 at 3:44 PM, observation of the outside cover of Resident #17's hard clinical chart revealed an attached label, titled "CPR" (which indicated staff were to perform CPR in the event of a respiratory or cardiac arrest). Review of the contents of the clinical record in the hard chart revealed a a form located in the front section of the chart, titled Cardiopulmonary Resuscitation, and included an order for CPR to be initiated in the event of cardiac or respiratory arrest. Resident #24 signed the form on 11/7/23, and the physician signed the form on 11/8/23. The hard chart included documentation of a second form in a separate section of the resident's chart, titled Iowa Physician Order for Scope of Treatment (IPOST), which included an order for the resident to be DNR. The resident's durable power of attorney for healthcare (DPOA) and a healthcare practitioner signed the form on 7/10/25. On 7/21/2025 at 3:51 PM, during an interview, the Director of Nursing (DON) reported she did not realize that the CPR identification label on the outside of the chart did not get changed when Resident #17 started hospice. A physician order, dated 7/10/25, included an order Resident #17 to start hospice services. On 7/21/25 at 3:53, the DON reported staff	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0578 SS = D	Continued from page 2 would look at outside of the hard chart in an emergency to determine whether or not they should perform CPR. The DON reported a plan to update the label on Resident #17's hard chart to DNR status immediately. Review of the facility's policy, titled Advanced Directives, dated 3/17/2008, revealed the facility respected the right of each resident to make decisions regarding their healthcare, including the right to accept or reject care, execute a living will or durable power of attorney, and determine CPR/DNR status.	F0578		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by:	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 3 Based on clinical record review, review of facility incident reports, review of facility policy, family member and staff interview, the facility failed to ensure staff followed their policy for reporting allegations of abuse for 1 of 1 sampled residents (Resident #17) reviewed with an allegation of abuse. The facility reported a census of 30 residents. Review of the Minimum Data Set (MDS) assessment for Resident #17, dated 6/9/25, identified the resident had a diagnosis of dementia. The assessment included a Staff Assessment for Mental Status which indicated Resident #17 had short term and long term memory problems. The Cognitive Skills for Daily Decision Making assessed the resident as Severely impaired (defined as never/rarely made decisions). The MDS identified the resident required supervision or touch assistance to for a chair/bed-to-chair transfer, transfer to toilet, and tub/shower transfer; and partial or moderate assistance for sit to stand, sit to lying, and lying to sitting on side of bed. Review of the Care Plan for Resident #17,initiated 8/9/23, revealed a Focus area to address [name redacted] is at risk for falling r/t (related to) dementia, inability to recognize safety hazards. Interventions included, in part:a. Ambulate resident with assist x 1 (with one staff) with gait belt. Date initiated: 3/18/25.b. Assist [name redacted] to transfer/ambulate with hand held assistance as she is safe and able. Date revised: 11/14/23. During an interview on 7/21/25 at 5:15 PM, Resident #17's family member reported concerns with the resident having bruising on their wrist about 9 months to 1 year ago. They explained during that same time period that the family member witnessed Staff A, Certified Nurses Aide (CNA), be rough with the resident. The family member stated they saw Staff A grab the resident tightly around the wrists and jerk the resident out of her wheelchair. The family member explained that the family member immediately reprimanded Staff A and told the Administrator. The family member explained the resident already had a bruise on her wrist at the time, and the family member was unsure if the incident the family member witnessed had caused the resident any bruising or injury. The family member could not remember the exact date, day of the week or time of day that the incident occurred. A review completed on 7/23/25 of the facility's Incident/Accident Report forms from August 2024 through July 2025 r/t Resident #17 revealed one report dated 7/9/25. The 7/9/25 report documented the need for a staff to lower the resident to the floor due to weakness. No reports related to Resident #17 found during this time frame. Review of a Non-Pressure Report in Resident #17's clinical record, dated 8/20/24,	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 4 revealed the resident had a right wrist bruise, deep purple in color and superior to green and yellow bruising. The Non-Pressure Report identified the bruised area healed 9/25/24. During an interview on 7/23/2025 at 10:47 AM, the Administrator denied any reports from family or residents with complaints of rough handling by staff, or concerns of a staff person inappropriately grabbing a resident. The Administrator explained that if she received a report of alleged abuse, she would get a report of what happened, write down the information and investigate. The Administrator reported she would have the staff member give involved in the allegation explain their side of what had happened. The Administrator reported that she would not have that person continue working during the investigation. If there was an allegation of abuse, the Administrator reported she would turn this into the State. During an interview on 7/23/2025 at 10:57 AM, Staff C, CNA, and Staff B, Licensed Practical Nurse (LPN), both reported they had not seen or heard of a staff person that was rough with resident. They had not seen or heard of a staff person grabbing a resident tightly, jerking a resident out of their chair, or inappropriately transferring a resident. During an interview on 7/23/2025 at 11:49 AM, the Director of Nursing (DON) reported she had never had a family member voice concerns in regards to Staff A, CNA, or any other staff. The DON denied having seen or heard of any of the staff inappropriately transferring or being rough with a resident. During a second interview on 7/23/2025 at 12:26 PM, Resident #17's family member reported they misspoke. The family member reported they had not notified the Administrator of the incident they witnessed that involved Staff A, CNA, 9 months to a year ago. The family member recalled they notified the charge nurse when the incident happened with Staff A, CNA. The family member identified the nurse was Staff B, LPN. The family member recalled Staff B, LPN, mentioned the bruising on the resident's wrist, and the family member said to Staff B, "I know exactly how it happened." The family member explained they then told Staff B the incident they had witnessed that involved Staff A, CNA. The family member reported they were in the resident's room when Staff A, CNA, grabbed Resident 17's wrists tightly and jerked her out of her (wheel) chair. The family member stated, "there was nothing gentle about it." The only persons present in the room when the incident occurred were Resident #17, Resident #17's family member, and Staff A. During an interview on 7/23/2025 at 12:55 PM, Staff B, LPN, when asked if she remembered a family member talking with her about a problem with Staff A, CNA transferring Resident #17, Staff B, stated, "I think so. I think (family member) did say something about the way staff was holding	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 5 (Resident)'s wrists." Staff B explained the family member reported Staff A was holding Resident #17 around the wrist instead by the hands. Staff B remembered Resident had bruising around the wrist at one time, but Staff B was not sure if that was the same time period of the incident. Staff B reported she did not recall the time frame of when the incident happened. Staff B did not remember if the family member said something about staff grabbing the resident's wrist. Staff B did not remember if she told anyone; Staff B thought she told the DON, but she explained that she honestly didn't remember. Staff B thought she probably talked with Staff A, CNA, about what happened. Staff B, LPN, stated, "I probably reminded all of them to hold her by her hand and not by her wrist." Staff B, LPN, explained that if someone reported to her a concern of staff treatment of a resident, she was supposed to let the Administrator or the DON know. During an interview on 7/23/2025 at 1:43 PM, the Administrator and DON, the Administrator reported they would have investigated the concerns reported by Resident #17's family member if they would have known, and reported the concern to the State within 2 hours of knowledge of the incident. The Administrator stated, "(Staff A, CNA) would not have been working the floor during the investigation." During an interview on 7/23/2025 at 2:21 PM, Staff A, CNA, reported she had worked at the facility for almost two years. Staff A worked third shift during the week and first shift on the weekends. Staff A reported no problems when transferring Resident #17 if she had help. Staff A explained there was a little problem with transfers with the resident. Resident #17 "pulls back against" when transferring and Staff A explained they usually had two staff assist the resident for transfers. Staff A thought the resident was care planned as an assist of one. Staff A explained, "(I) usually grab (Resident #17's) hands and pull her up to stand, or if two people (assisting), get on either side (of the resident) and grab under the arms." Staff A denied ever grabbing the resident by her wrist to pull her up. Staff A did not remember a time when a family member reprimanded her about how Staff A pulled the resident up. Staff A denied Staff B, LPN, or any other staff person had talked to her about transferring the resident out of her chair inappropriately. Staff A reported she received training on how to perform appropriate transfer of residents when she started at the facility. Review of the facility policy, titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated 2024, revealed all allegations of abuse should be reported to the charge nurse. The charge nurse was immediately required to report allegations of abuse to the Administrator or designee representative.	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165476	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANORS OF COLUMBUS COMMUNITY	814 SPRINGER AVENUE , COLUMBUS JUNCTION, Iowa, 52738

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 6 Should an incident or suspected incident of abuse be reported or observed, the Administrator or designated management member would investigate the alleged incident.	F0607		

Plan of Correction

FACILITY NAME: Colonial Manors of Columbus Community

ADDRESS: 814 Springer Avenue

CITY, STATE, ZIP: Columbus Junction, IA 52738

SURVEY DATE: July 21-24, 2025

Provider # 165476

F578

The facility states that with respect to Resident #24 and all other similarly situated residents.

Resident #24's chart was updated immediately to ensure that proper code status was on the inside and outside of the resident chart.

The director of nursing has reviewed all resident charts to ensure that accurate resident code status (resident decision to have cardiopulmonary resuscitation (CPR) performed or do not resuscitate (DNR) in the event of cardiac arrest) is reflected on the outside of the resident chart, matching the code status on the inside of the resident's chart. The director of nursing has completed re-education with all nurses on staff to ensure that they know the procedure to follow when a resident has a change in code status.

Compliance will be monitored by the Director of Nursing or designee. The DON or designee will review code status documentation quarterly at resident care conference. Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Completion date: 8/23/25

Plan of Correction

FACILITY NAME: Colonial Manors of Columbus Community

ADDRESS: 814 Springer Avenue

CITY, STATE, ZIP: Columbus Junction, IA 52738

SURVEY DATE: July 21-24, 2025

Provider # 165476

F0607

The facility states that with respect to Resident #17 and all other similarly situated residents.

The Administrator and Director of Nursing (DON) reviewed the Abuse Prevention and Reporting Policy to ensure full compliance with regulations.

DON and administrator completed training with all staff on the facility abuse policy. All allegations of abuse will be reported and investigated as required by the facility policy.

Findings and compliance updates will be discussed during QAPI meetings. Additional training or policy adjustments will be made as needed.

Completion date: 8/23/25