Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 25, 2025

Administrator
The Estates at Delano LLC

433 COUNTY ROAD 30
DELANO, MN 55328

RE: CCN:245336
Cycle Start Date:

Dear Administrator:

On November 19, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 19, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 19, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
E0000	Initial Comments On 11/17/25 to 11/19/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		12/12/2025
F0000	INITIAL COMMENTS On 11/17/25 to 11/19/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The following complaints were reviewed with NO deficiencies cited: H53367588C (1119262) H53367587C (1119268) H53367586C (1119272) H53367585C (2618921) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		12/12/2025
F0628 SS = D	Discharge Process	F0628	Credible Allegation of Compliance:	12/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
F0628 SS = D	Continued from page 1 CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F0628	Continued from page 1 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute an admission of guilt or liability by the facility and is submitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: Immediate update to the Minnesota ombudsman's office for residents R37 and R38 who left the facility against medical advice. Updating the Minnesota ombudsman's office will be followed per Monarchs Discharging Against Medical Advice policy. Identification of Others at Risk: All residents who leave the facility who have left the facility against medical advice have the potential to be affected by this deficient practice. Systemic Changes: Monarch Healthcare Management has updated the Discharging Against Medical Advice policy as necessary to reflect updating the representative of the Office of the State Long-Term Care Ombudsman. The social worker has been educated on this new policy. The administrator or designee will conduct monthly audits on the Ombudsman report to ensure they include AMA discharges and will review with QA committee. Date of Compliance: 12/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0628 SS = D	Continued from page 2 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0628 SS = D	Continued from page 3 number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0628 SS = D	Continued from page 4 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure the Minnesota Ombudsman Office was informed of residents discharging against medical advice (AMA) for 2 of 3 residents (R37 and R38) who were reviewed for discharge from the facility. Findings include - R37: R37's electronic medical record (EMR) documented the following diagnoses: multiple fractures of ribs, left side subsequent to a motor vehicle accident, acute pain from trauma and muscle	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
F0628 SS = D	Continued from page 5 weakness. R37 was admitted to the facility on 9/25/25 and discharged against medical advice on 10/01/25, after not returning from an leave of absence (LOA). Review of R37's progress notes documented the following: > 9/30/2025 [9:45 p.m.] Writer was told in report resident was on LOA and will be back, around 9PM resident was not available, writer called resident phone and left a voicemail for resident to call facility> 10/01/2025 11:00 a.m., [business office manager] resident and left called a VM regarding his failure to return from LOA. Resident signed out and left the facility on 9/30/25 at about 1:30pm stating that he would return in a couple hours. Resident still has not returned call. [business office manager -BOM] also called resident's friend who did not answer. BOM left VM and a return call has not yet been made.> 10/01/2025 11:28 a.m., [social services designee] called resident phone number and resident's friend, [Friend-A], phone number. No answer. [social services designee] requested resident/[Friend-A] call the facility to give an update on whereabouts> 10/01/2024 12:41 p.m., Administrator called resident's phone and left a voice message. Administrator called resident's [Friend-A], Friend-A returned call quickly and stated that resident "is an adult and able to make his own decisions". [Friend-A] stated that he brought resident home and left. [Friend-A] stated that resident stated he was going to stay home and not return to the facility. [Friend-A] encouraged resident to call facility to let them know. Facility has not received a call back from resident. [Friend-A] stated that he was going to go to resident's house to check on him. [Friend-A] plans to update Administrator.> 10/01/2025 1:17 p.m., Administrator received return call from resident's friend [Friend-A]. [Friend-A] was able to get a hold of resident and instructed him to call The Estates at Delano. [Friend-A] confirmed that resident is at home and staying at home. Administrator was not able to speak with resident directly, so three additional calls were made to resident. Resident did not answer. Resident still has not made contact with facility.> 10/01/2025 4:44 p.m. At 2:20pm, Administrator and [social services designee] called 911 and requested a wellness check on resident at his personal address. 911 operated stated if resident was not found at address, a missing person's report will be filed. MAARC report was filed. Ombudsman notified. MAARC confirmation number: 1000244718.> 10/01/2025 at 5:12 p.m., [social services designee] attempted to call resident. No answer. [social services designee] left another voicemail.> 10/01/2025 6:25 p.m., Administrator called McLeod County Sheriff's department for an update on wellness check. Sheriff stated that the officer that was on call during the wellness check was not able to	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0628 SS = D	Continued from page 6 make contact with resident. Sheriff stated that it was written in the notes, "person working at business hasn't seen him in a month". Sheriff was unable to state what the business was or who the business person was. Sheriff reached out to the Sheriff on duty during the wellness check. The sheriff called administrator back and stated that the officer that was on duty stated it is an apartment building attached to a business. There is a person at front desk monitoring ins and outs, and they had stated that they have not seen this resident for a month. Administrator told sheriff that she would be filing a missing persons report. Sheriff agreed and instructed administrator to do so with Wright County.> 10/01/2025 6:53 p.m., Administrator filed missing person report #25027552 with Wright County Sheriff Department.> 10/01/2025 7:11 p.m., [Deputy-A] arrived to facility and called Administrator for more information. [Deputy-A] stated he was going to try to find resident tonight and would update administrator with additional details.> 10/01/2025 8:20 p.m., [Deputy-A] called administrator stating that [R37] has been found safe at home. [R37] returned administrator's call stating he would like to be discharged AMA from The Estates at Delano. MAARC completed by SS 10/1/2025. Administrator discharged resident at 8:22pm. During interview on 11/18/2025 at 4:21 p.m., the facility assigned ombudsman (OMBUD)-A, after referencing her records, stated she had received an email from the social service designee (SSD) on 10/01/25 at 2:52 p.m., indicating R37 had left the facility yesterday with a friend and never returned. The email indicated they had involved the police to do a wellness check and had filed a MAARC (Minnesota Adult Abuse Reporting Center) report with the state of Minnesota. OMBUD-A stated she was uncertain if the facility had included R37 in their monthly report to the Office of Ombudsman but would check with the office's staff. On 10/01/2025 at 5:01 p.m., survey received a TEAMS Chat message indicating the facility had not included R37's AMA discharge to the Office of Ombudsman. R38: R38's electronic medical record (EMR) documented the following diagnoses: urinary tract infection, morbid obesity, muscle weakness, unsteady on feet and history of falling. R37 was admitted to the facility on 10/22/24 at approximately 4:00 p.m., and discharged against medical advice on 10/24/24 at approximately 12:00 p.m. (approximately 44 hours after admission) with family. A review of R38's Discharge Planning (dated 10/23/24) INDICATED: "Resident would like to recover from his fall and return home with spouse." In review of R38's electronic medical record progress notes, the following was documented: > 10/24/2024 10:12 a.m. Behavior Note Text: Met with resident this morning after hearing that he was more	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0628 SS = D	Continued from page 7 confused during the night and was out in the hallway nude. [Director of nursing] confirmed with staff that they saw the Resident come out of his room nude. They immediately intervened and brought him back to his room and got him dressed. The resident stated that he is not sure how he became nude. He stated "I found a door to go out of and then I was in a long hallway. People were in the hall. They found me these clothes. I don't know how they got on me or how they got here, but I recognize the pants." When asked if he slept in his bed or in the chair last night, the resident stated that he did sleep some in his bed but also got up into the chair. [Director of nursing] attempted to notify [(Fam)-A], with Resident's permission. Fam-A had called the facility concerned about her father's behaviors. DON left a voicemail for Fam-A to call back when she was able.> 10/24/24 at 12:02 p.m. Resident's [family] arrived at facility. DON, Administrator, and SSD spoke with family to update them on how resident was doing and to answer any questions. Family was concerned resident should go to hospital. Staff assured family resident was safe at facility and if staff noted any concerns, the facility would send resident to the hospital. Family did not agree and requested to discharge resident AMA. [Director of nursing] and Administrator educated family on the risks of discharging AMA. Family understood but decided to d/c AMA. Staff interviewed resident to ensure resident was okay. Resident stated he did not mind being at the facility but wanted to please his wife and daughter and do what they asked. Family signed AMA paperwork. Family stated they would be bringing resident to the hospital.> 10/24/24 at 12:55 p.m. MAAR report filed due to resident leaving AMA. Thu Oct 24 2024 12:53:50 confirmation number: 1000204449 During interview on 11/18/2025 at 4:21 p.m., the facility assigned ombudsman (OMBUD)-A, after referencing her records, stated she had received an email from the social service designee (SSD) on 10/24/24 at 12:55 p.m., indicating R38 had left the facility AMA and the facility had filed a MAARC report. OMBUD-A stated she was uncertain if the facility had included R38 in their monthly report to the Office of Ombudsman but would check with the office's staff. During interview on 11/19/25 at 10:48 a.m., SSD stated she had contacted OMBUD-A on both R37 and R38 via email, which were provided. However, when SSD reviewed the monthly reports sent to the Office of Ombudsman (copies kept in a three ring binder), which should have included both residents names, dates of discharges and reason for the discharges, SSD not R37's and R38's names were not included. SSD stated the program they use requires her to trigger filters to gather the names and reasons for facility discharges. SSD stated the filter for AMA had	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0628 SS = D	Continued from page 8 not been selected, when the reports for R37 and R38 were run. In review of the requested facility policy for reporting discharges to the the Office of Ombudsman, the facility provided the policy entitled: Ombudsman Hospital Transfer Report (dated 08/2025). The policy documented the following: Purpose -Copies of notices for emergency transfers must be sent to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis. "Procedure - 1. This report is sent monthly, typically within the first 5 days of the month for the previous month.2. Run the report on [Point Click Care - PCC], using the following instructions: a. In PCC, go to Admin tab b. Reports c. Action Summary Report d. Ensure you date range is correct e. Action Code - Clear it all and then scroll to the bottom and click i. "Transfer out to hospital" ii. :Discharge Date" iii. "Discharge/Transfer New Facility" f. Ensure all Payer Types are selected g. Click "Show to / from description" h. Run report3. Fax printed report to the Ombudsman at 651-431-7452\4.4. Once faxed, print and fax confirmation5. Keep the Fax Cover Sheet, Report and Fax Confirmation together in a file folder or binder."	F0628		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure there were orders and interventions in place for continuous positive airway pressure (CPAP) machine usage for 1 of 1 residents (R16) reviewed for CPAP therapy. Findings include: R16's quarterly Minimum Data Set (MDS) dated 10/7/25, identified R16 was cognitively intact and required assistance with all cares. Diagnoses included congestive heart failure (CHF), diabetes, atrial fibrillation, chronic kidney disease, end stage renal	F0695	Credible Allegation of Compliance: Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute an admission of guilt or liability by the facility and is submitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: Ensured that R16 got CPAP orders in place immediately. Immediate reeducation was provided to nursing staff responsible for putting CPAP orders in place for R16. CPAPS will have an order in place per Monarchs Medication and Treatment Orders policy. Identification of Others at Risk: All residents who wear a CPAP within the facility have the potential to be affected by this deficient practice. In review, there are no current residents residing in the facility that utilize a CPAP. Systemic Changes:	12/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
F0695 SS = D	Continued from page 9 disease, obstructive sleep apnea, chronic respiratory failure and asthma. R16's care plan initiated 7/9/25, identified R16 had an alteration in oxygen/gas exchange, respiratory status related to sleep apnea and chronic respiratory failure. Interventions included CPAP at bedtime for sleep apnea. R16's physician orders dated 11/17/25 failed to indicate orders to wear CPAP machine at night, clean CPAP mask and tubing or to replace CPAP supplies. On 11/17/2025 at 11:12 a.m., R16's CPAP machine was observed on pole, the tubing was draped over the machine, the face mask was noted to have an unknown brown, crusty substance around the perimeter of the cushion. When interviewed on 11/17/25 at 4:55 p.m., R16 stated she wore her CPAP every night, needed assistance from staff to put the mask on. R16 was not sure when the mask and tubing were cleaned by staff. On 11/19/2025 at 11:23 a.m., observed R16's CPAP tubing was draped over the bottom rail of the bed with the CPAP mask facing the floor about six inches from the floor with the headgear resting on the floor under the bed. The CPAP mask was noted to have an unknown dried, white substance on the cushion. When interviewed on 11/19/2025 at 1:34 p.m., nursing assistant (NA)-A stated R16 wore the CPAP every night, needed assistance to put it on. NA-A stated the nurses took care of the CPAP machine. NA-A she R16 wore her CPAP every night When interviewed on 11/18/2025 at 1:42 p.m., PM NA-B stated the nurses took care of the CPAP machine, but the nursing assistants helped her put the mask on when R16 went to bed. NA-B stated R16 wore the CPAP every night. When interviewed on 11/18/2025 at 1:45 p.m., registered nurse (RN)-A stated there should be orders in R16's electronic medical record (EMR) for R16 to wear the CPAP every night, cleaning the tubing and mask and	F0695	Continued from page 9 Director of Nursing or designee will conduct random audits to ensure compliance 3x weekly for 1 week, weekly for 3 weeks, monthly for 2 months, and will review with QA committee for further recommendations. Date of Compliance: 12/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
F0695 SS = D	Continued from page 10 replacing supplies. RN-A was not able to locate any orders regarding R16's CPAP in the EMR. RN-A was not sure when the CPAP tubing and mask were cleaned but knew another nurse had recently replaced the mask When interviewed on 11/18/2025 at 1:55 p.m., director of nursing (DON) stated there should be orders in the EMR for CPAP. DON was not certain why there were no orders located in R16's EMR. Facility policy regarding CPAP machines was requested, however, none was provided.	F0695		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F0842	Credible Allegation of Compliance: Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute an admission of guilt or liability by the facility and is submitted solely in response to regulatory requirements. Corrective Action for Affected Individuals: Ensured that R16 received provider orders for frequency of Dexcom sensor changes and nursing orders to ensure pressure dressing removal orders to dialysis fistula site were in place immediately. Immediate reeducation was provided to nursing staff responsible for putting Dexcom sensors and pressure dressing orders in place for R16. Education was provided by utilizing Monarchs Medication and Treatment Orders policy and hemodialysis policy. Identification of Others at Risk: All residents who utilize a Dexcom device and have dialysis ports within the facility have the potential to be affected by this deficient practice. There are currently no other residents residing in the facility that have a dialysis port. Alike residents who utilize a Dexcom device were reviewed to ensure that appropriate sensor changes were received from the provider. Systemic Changes:	12/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0842 SS = D	Continued from page 11 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by:	F0842	Continued from page 11 Director of Nursing or designee will conduct random audits to ensure compliance 3x weekly for 1 week, weekly for 3 weeks, monthly for 2 months, and will review with QA committee for further recommendations. Date of Compliance: 12/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	**433 COUNTY ROAD 30 , DELANO, Minnesota, 55328**

(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
F0842 SS = D	Continued from page 12 Based on interview and document review, the facility failed to ensure there were orders in place for Dexcom sensor (a wearable Continuous Glucose Monitoring (CGM) system for people with diabetes) for 1 of 3 residents (R16) reviewed for Dexcom use. In addition the facility failed to ensure orders were in place to remove pressure dressing (bandage applied to stop bleeding) after dialysis (medical procedure filters and removes waste from blood) for 1 of 1 residents (R16) reviewed for dialysis. Findings include: R16's quarterly Minimum Data Set (MDS) dated 10/7/25, identified R16 was cognitively intact and required assistance with all cares. In addition the MDS indicated R16 received dialysis. Diagnoses included congestive heart failure (CHF), diabetes, atrial fibrillation, chronic kidney disease, end stage renal disease, obstructive sleep apnea, chronic respiratory failure and asthma. Review of R16's progress notes identified nurses had replaced R16's Dexcom sensor on 9/23/25, 10/4/25, 10/17/25 and 11/17/2025. R16's orders dated 11/17/25, directed nurses to monitor R16 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) and to check blood sugars four times daily. However, R16's electronic medical record (EMR) failed to contain orders to change R16's Dexcom every 10 days. R16's orders directed staff to obtain vital signs after dialysis and monitor site every shift for bruit (listening for turbulent blood flow) and thrill (feel for vibration of blood flow) however, the R16's EMR failed to contain orders to remove the pressure dressing following dialysis. R16's care plan initiated 5/2/25, indicated R16 was at risk for complications related to dialysis with interventions which included dialysis per schedule and treatment and dressing protocol to dialysis site per order. When interviewed on 11/17/25 at 4:55 p.m., R16 stated the nurses check her blood sugars with the use of her Dexcom sensor. R16 further stated facility staff did not remove the pressure dressing from the dialysis fistula (dialysis access) site, she removed the dressing herself the day after receiving dialysis.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
F0842 SS = D	Continued from page 13 When interviewed on 11/18/2025 at 1:45 p.m., registered nurse (RN)-A stated there should be orders in R16's EMR to have the Dexcom sensor replaced every 10 days. RN-A was not able to locate any orders regarding R16's Dexcom application in the EMR. When interviewed on 11/18/2025 at 1:55 p.m., director of nursing (DON) stated there should be orders in the EMR to change R16's Dexcom sensor, DON was unable to locate an order and was not sure how the nurses had changed the Dexcom when there was not order in the EMR for them to do so. When interviewed on 11/18/25 at 1:55 p.m., RN-B was not sure about an order to removed R16's pressure dressing after dialysis, has removed it at times but not on a regular basis. When interviewed on 11/18/25 at 2:30 p.m., DON stated there was an order to monitor every shift for bruit and thrill in R16's EMR, but was unable to locate an order to remove the pressure dressing and would have to check into that. During follow-up interview on 11/18/25 at 2:40 p.m., DON stated R16 had previously been admitted to the hospital, all orders had been discontinued at that time. The Dexcom order had not been re-started upon R16's return to the facility. DON stated checked on removal of dressing, should be removed four to six hours after dialysis. DON was not sure why R16 did not have an order to remove the dressing. Facility policy regarding Dexcom and/or CGM use was requested however, was not provided. Facility Hemodialysis policy dated 11/22/19 was provided, however, the policy does not address removal of pressure dressing after dialysis.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.2, 13.3.2.2, and 13.3.3.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/19/2025 at 10:20 AM, it was revealed by observation that the indicator on the main fire sprinkler valve of the riser was showing a partially closed position. However, the fire sprinkler company confirmed during a quarterly inspection that the valve	K0353	Immediate Corrective Action: Appropirate contractor came out to the facility to fix/replace sprinkler valve on the riser as it was showing partially closed. This was fixed on 12/3/25, and the valve is now vertical. Date of Compliance: 12/12/25 Re-occurrence will be prevented by: Audited the main fire sprinkler valve to ensure that it was vertically to be sure that valve is completely open. Corrections will be monitored by: Maintenance Director/ Designee	12/12/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
K0353 SS = F	Continued from page 1 is fully open. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
K0521 SS = F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on observations and staff interview, the facility failed to install the heating, ventilation, and air conditioning per NFPA 101 (2012) Life Safety Code, section 19.5.2 and NFPA 90A (2012) Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/19/2025 between 08:45 AM and 10:30 AM, it was revealed by observatoin that the HVAC systems for the building was using the corridor system as part of the air distribution system for make-up air for the bathroom exhaust. There are no return air ducts in the resident rooms, and the corridor is being used as a return plenum. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0521	Immediate Corrective Action: Appropirate action was taken to request a hardship waiver on 12/3/2025 for HVAC system deficiency within the facility. Sent via email to fire marshal with cost estimate. Date of Compliance: 12/12 Re-occurrence will be prevented by: Asked for hardship wavier and got a quote, due to the cost and no harm is being done to residents, facility continues to ask for hardship wavier. Corrections will be monitored by: Maintenance Director/ Designee	12/12/2025
K0345 SS = C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code.	K0345	Immediate Corrective Action: Appropriate electrical conduit was installed on the fire alarm wiring connected to the waterflow switch. This was completed 12/3/25 Date of Compliance: 12/12/25	12/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
K0345 SS = C	Continued from page 2 Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.3, and NFPA 70, (2011 edition), National Electrical Code, sections 760.24, 760.53, and 300.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/19/2025 at 10:20 AM, it was revealed by observation, that the fire alarm wiring connected to the fire sprinkler waterflow switch and the main control valve on the main sprinkler riser was not installed in electrical conduit. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	Continued from page 2 Re-occurrence will be prevented by: Audited the fire alarm wiring after insulation of conduit to ensure that it was completed by a contracted vendor. Corrections will be monitored by: Maintenance Director/ Designee	
K0712 SS = C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.4. This deficient finding could have a widespread impact on the residents within the facility.	K0712	Immediate Corrective Action: Appropirate action was taken by educating the maintenance director on the importance of having sounding drills on day shift and evening shift. Reviewed Monarchs fire drill policy and life safety regulations with maintenance director. Date of Compliance: 12/12/2025 Re-occurrence will be prevented by: Admin or designee will audit the fire drills from the maintenance director to ensure that they were sounding alarm drills during day shift and evening shift. Corrections will be monitored by: Maintenance Director/ Designee	12/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
K0712 SS = C	Continued from page 3 Findings include: On 11/19/2025 between 08:45 AM and 10:30 AM, it was revealed by a review of available documentation, the documentation for the February 11, 2025, fire drill at 4:05 PM indicates that the drill was conducted by announcement instead of activating the fire alarm system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712		
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/19/2025. At the time of this survey, The Estates At Delano was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections	K0000		12/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
K0000 Bldg. 01	Continued from page 4 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Delano is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II (000) construction. In 1988 a single story addition was constructed to the South Wing and determined to be of Type II (000) construction. An addition was constructed in 2008 and was determined to be Type II (000) to the East Wing. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 39 beds and had a census of 33 at the time of the survey.	K0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	433 COUNTY ROAD 30 , DELANO, Minnesota, 55328

(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
K0000 Bldg. 01	Continued from page 5 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K521	Waiver request for November 2025 Life Safety Code Inspection. Waiver request submitted on 12/3/25 via email. Currently, The Estates at Delano is using the corridors for both North and South wings as part of the heating, ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is being requested for the following reasons: 1. There will be no adverse effect on the health and safety of the facility's residents, family members, and staff because the building is equipped with an approved full smoke detector system, along with an automated full shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or sprinkler system. 2. The facility is protected by a 24-hour supervised automatic sprinkler system. 3. The internal facility is smoke-free and signs are prominently posted at all major entrances/exits. There is a designated exterior smoking area on the far end of the patio in the back of the building, used only by a few residents. The area is equipped with approved metal self-closing containers for used cigarettes. 4. Annual service and maintenance contracts exist to service all the facility's fire protection system including fire alarm, sprinkler system, and portable extinguishers. 5. The building fire alarm system is monitored to provide automatic fire department notification. 6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 7. Fire drills are conducted quarterly on each shift. 8. Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. The initial bid also proposed the installation of duct work that would negatively affect the structural integrity of the building. The Estates at Delano was not able to find a more cost effective solution for making the ventilation system upgrades to meet the current codes NFPA 90 A.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* *Travis J. Ahrens 49207*	Title Fire Safety Supervisor	Office MN State Fire Marshal Div.	Date 12/3/25

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 22, 2026

Administrator
The Estates at Delano LLC
433 COUNTY ROAD 30
DELANO, MN 55328

RE: CCN: 245336
Cycle Start Date: November 19, 2025

Dear Administrator:

On December 15, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112