

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 25th, 2018

Ms. Leah Schreder, Administrator The Estates At Delano LLC 433 County Road 30 Delano, MN 55328

Subject: The Estates At Delano LLC - IDR

CMS Certification Number (CCN) 245336

Project # S5336026

Dear Ms. Shreder:

This letter is in response to your June 26th, 2017 request for an Informal Dispute Resolution (IDR) for the federal deficiencies at tags F225 and F226 issued pursuant to the survey event BBZQ11, completed on June 2nd, 2017.

The information presented with your request, the CMS 2567 dated June 2nd, 2017, corresponding plan of correction, as well as other survey documents and discussing with facility representatives as well as the Department's survey staff have been carefully considered, and the following determination has been made:

F225 Scope and severity (S/S) – J – 42 CFR § 483.12 (a) (4)(c) (1) The facility must ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately and not later than 24 hours if the events that cause the allegation do not involve abuse, and do not result in bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation or mistreatment while the investigation in in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Appendix Q of the SOM provides guidance for surveyors in determining whether or not residents are in

The Estates At Delano LLC May 25, 2018 Page 2

an Immediate Jeopardy situation. The Guidelines clarify that actual harm as well as the potential (emphasis added) for harm, to one or to more than one individual may constitute an IJ. The identification and removal of IJ, either psychological or physical, is essential to prevent serious harm, injury, impairment, or death for individuals. Appendix Q indicates that:

- Only ONE INDIVIDUAL needs to be at risk. Identification of IJ for one individual will prevent risk to other individuals in similar situations.
- Serious harm, injury, impairment, or death does NOT have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ. If the team identifies an IJ situation, the following points are to be considered:
- The entity either created or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.
- The entity had an opportunity to implement corrective or preventive measures.

F226 S/S – F – 42 CFR §483.12 (b) The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.

Summary of the facility's reason for the IDR of these tags: The facility alleges they were not aware the incident that triggered the deficiency citation rose to the level of a reportable incident which would have required an abuse investigation and reporting to the State Agency, until the survey staff notified the director of nursing (DON) and administrator on May 31st, 2017, during the course of the survey. When the facility became aware of an allegation of verbal abuse toward R15, the facility immediately implemented their abuse prohibition policy, which included suspending the alleged perpetrator, nursing assistant (NA)-C, and conducting a thorough investigation into R15's allegation which did not ultimately find that abuse occurred.

Summary of facts: R15 was a cognitively intact resident, who was able to express her thoughts and ideas clearly. R15's diagnoses included paraplegia, sacral pressure ulcers, anxiety disorder, major depression and borderline personality disorder. R15 required extensive assistance of two staff for repositioning in her bed and transfers. R15's care plan reviewed during the survey also indicated R5 had behavioral history of yelling at staff, throwing things at staff, and telling staff to get out of her room when she did not like what they were telling her regarding cares, etc.

During the course of the annual recertification survey on 5/30/17, at 12:35 p.m., R15 reported she had been abused "emotionally," by staff at the nursing home. R15 told the surveyor that NA-C had come into her room on 5/2/17, accompanied by NA-B to assist her to reposition in the bed. R15 reported she questioned NA-C about the last time she was repositioned, and NA-C raised her voice, became upset and told R15 she was not listening in a progressively louder tone of voice. R15 stated she told NA-C she was going to have her written up, NA-C left the room and returned with a grievance form for R15 to fill out, with NA-C's name spelled out and handed it to her stating, "in case you don't know how to spell." R15 verified she had never turned in the grievance form because she was concerned about the sequence of events and ensuring she filled it out accurately. R15 stated, "I just messed up. How can I report it if I

don't' get it exactly right." R15 reported NA-B witnessed the entire incident, and that no other staff

The Estates At Delano LLC May 25, 2018 Page 3

had come to talk to her about the altercation.

During survey, interviews with R15, NA-B and NA-C were conducted on 5/30/17. R15 stated she had been abused "emotionally" by staff and had stated she'd felt "nervous and afraid....I felt threatened that night." R15 said on 5/2/17 she'd had an altercation with NA-C about her repositioning schedule. R15 stated NA-C had been "yelling" at her and that NA-C had stated, "I'm not yelling, but if you want me to yell, I can yell." R15 stated she had called NA-C a "bitch" and NA-C had stated back, "I'm not being a bitch but can be" and repeatedly attempted to explain to R15 when she had last been repositioned. NA-B acknowledged there'd been an altercation on 5/2/17 and confirmed R15 and NA-C had argued. NA-B also stated NA-C had repeatedly attempted to make her point prior to walking out of the room. NA-B stated she'd reported the incident to the nurse at the time however, could not recall the nurse's name. NA-C had stated during interview she recalled the altercation. NA-C said R15 had cussed at the aides (she and NA-B) and had accused her of yelling. NA-C confirmed she'd stated to R15, "You're not taking my answer" and verified she'd provided R15 a grievance form to fill out, and had spelled out her name stating, "My last name is difficult to spell." NA-C further acknowledged she'd stated to R15 she "could be a bitch, but was not trying to be."

A progress note indicated RN-A had been aware on 5/2/17 there had been an altercation between R15 and NA-C. The progress notes indicated the resident had cussed at NA-C, and that NA-C had informed her, "I was not yelling or mad." Post survey, RN-A told the surveyors during interview that she had attempted to talk with R15 on 5/2/17, but she'd been sleeping, but had checked back and had asked R15 about the incident. RN-A said R15 had told her about the situation, but had not indicated she felt emotionally or verbally abused.

The director of nursing (DON) and administrator were also interviewed during survey. On 5/31/17, the DON stated this was the first "I have heard about this" when informed by survey staff that R15 had reported feeling "emotionally abused." The DON had reviewed the progress note and acknowledged she couldn't see that any follow up had occurred related to the incident. The administrator stated the incident had just been explained to him.

Summary of findings: After careful review of the deficient practice, interviews with survey and facility staff, it was determined an altercation did occur between R15 and NA-C on 5/2/17. NA-C verified she had argued with R15 and had stated to R15, "I'm not being a bitch but can be." NA-B verified being present during the altercation, and hearing this exchange. NA-B verified having reported the altercation to RN-A. RN-A's progress note verified the allegation had been reported to her however, she did not report the allegation to the Director of Nursing or Administrator and an investigation was not initiated. NA-C continued to work with residents between 5/2 and 5/30/17 when the survey team brought the allegation to the facility's attention. During that time, there was no evidence NA-C had received any re-education or feedback related to how she responded to R15, and there was no evidence she had received any additional supervision/oversight performing care.

This is a valid example at F225 and F226 and is appropriately cited at s/s IJ.

This concludes the Minnesota Department of Health informal dispute resolution process. Please note, it is your responsibility to share the information contained in this letter and the results of The Estates At Delano LLC May 25, 2018 Page 4

this review with the President of your facility's Governing Body.

Sincerely,

Holly Kranz, RN, LNHA, Mankato Unit Supervisor

Hally Kranz

Licensing and Certification Program

Health Regulation Division

Telephone: (507) 344-2742 Fax: (507) 344-2723

Cc: Office of Ombudsman for Long-Term Care

Pamela Kerssen, Assistant Program Manager

Licensing and Certification File

Brenda Fischer, St. Cloud A Unit Supervisor



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245336 August 14, 2017

Mr. Don Flack, Administrator The Estates At Delano Llc 433 County Road 30 Delano, MN 55328

Dear Mr. Flack:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 17, 2017 the above facility is certified for or recommended for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

The Estates At Delano Llc August 14, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 14, 2017

Mr. Don Flack, Administrator The Estates At Delano Llc 433 County Road 30 Delano, MN 55328

RE: Project Number S5336026

Dear Mr. Flack:

On June 20, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective June 25, 2017. (42 CFR 488.422)

Furthermore on June 20, 2017, this Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at 225. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at 314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at 323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on June 2, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 21, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on June 2, 2017, as of July 17, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 17, 2017.

The Estates At Delano Llc August 14, 2017 Page 2

However, as we notified you in our letter of June 20, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 2, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of June 20, 2017:

- Civil money penalty for the deficiency cited at 225. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at 314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at 323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 14, 2017

Mr. Don Flack, Administrator The Estates At Delano Llc 433 County Road 30 Delano, MN 55328

Re: Reinspection Results - Project Number S5336026

Dear Mr. Flack:

On July 27, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 2, 2017, with orders received by you on June 20, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: BBZQ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	ΓE SURVEY AGENCY		Facility ID: 00933	
MEDICARE/MEDICAID F	PROVIDER	3. NAME AND AL				4. TYPE OF ACT	TION: 2 (L8)	
NO.(L1) 245336		(L3) THE ESTAT		NO LLC		1. Initial	2. Recertification	
2. STATE VENDOR OR MEI	DICAID NO.	(L4) 433 COUNT			G 0 FF339	3. Termination	4. CHOW	
(L2) 655371100		(L5) DELANO, N	AN		(L6) 55328	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHAN	GE OF OWNERSHIP	7. PROVIDER/SU		GORY	<u>02</u> (L7)	8. Full Survey At	fter Complaint	
(L9) 03/01/2017		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Tun survey in		
6. DATE OF SURVEY	06/02/2017 ^[L34]	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR EN	DING DATE: (L35)	
8. ACCREDITATION STATU 0 Unaccredited 1	S: (L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	12/31		
	3 Other	04 SINF	06 OF 1/SF	12 KHC	10 HOSFICE	12/31		
11LTC PERIOD OF CERTIFI	ICATION	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Require	ements:	
To (b):			equirements		2. Technical Personnel	6. Scope of	Services Limit	
		•	e Based On:		3. 24 Hour RN	7. Medical		
12.Total Facility Beds	54 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI	<u> </u>		
13.Total Certified Beds	54 (L17)	X B. Not in Con	npliance with Pro	gram	<u>x</u> 5. Life Safety Code	9. Beds/Roo	om	
		Requirements	and/or Applied	Waivers:	* Code: B *,5	(L12)		
14. LTC CERTIFIED BED BR	EAKDOWN				15. FACILITY MEETS			
18 SNF 18/1	9 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
	54							
(L37) (L	.38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENC	Y REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
	,			,				
17. SURVEYOR SIGNATURE	E	Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Bruce Melchert, I	HE NE II		07/08/2017	(L19)	Kamala Fiske-Downing	Enforcement Spe	ecialist 07/24/2017 (L20	
	PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	(
19. DETERMINATION OF E	LIGIRII ITY	20. COM	IPLIANCE WITI	H CIVII.	21 1 Statement of Fina	uncial Solvency (HCFA-2	2572)	
			HTS ACT:	. CIVIL	Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
2. Facility is not	gible to Participate				3. Both of the Abov	e :		
2. Facility is not	(L21)							
22. ORIGINAL DATE	22 TEG 4 GREEN		mg . gp.pp	450 Jm	A (TERM TO) (CTYO) (CTYO)		(7.20)	
	23. LTC AGREE		4. LTC AGREEN		26. TERMINATION ACTION	_	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00		<u>UNTARY</u>	
07/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimburs		to Meet Health/Safety	
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination		to Meet Agreement	
25. LTC EXTENSION DATE		VE SANCTIONS			04-Other Reason for Withdrawal	OTHER	=	
	A. Suspensio	n of Admissions:	(L44)		or other reason for windrawa.	07-Prov 00-Acti	vider Status Change	
(L	.27) B. Rescind S	uspension Date:	(L44)			00 71011	,,,	
		•	(L45)					
28. TERMINATION DATE:	20	9. INTERMEDIARY/			30. REMARKS			
20. TERMINATION DATE.	2,		CHRICIER NO.		50. REMINICIS			
	(1.20)	01111		(121)				
	(L28)			(L31)	Emailed ROCHI Annual W	aiver K521 - 07/25/20	17 Co.	
31. RO RECEIPT OF CMS-15	39 32	2. DETERMINATION	OF APPROVAI	DATE	Posted 07/25/2017 Co.			
	(L32)			(1.22)	DETERMINIATION APP	DOWAL		
	(L34)			(L33)	DETERMINATION APP	KUVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted June 20, 2017

Mr. Don Flack, Administrator The Estates At Delano LLC 433 County Road 30 Delano, MN 55328

RE: Project Number S5336026

Dear Mr. Flack:

On June 2, 2017, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate

jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 2, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Minnesota Department of Health Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 brenda.fischer@state.mn.us

Telephone: (320)223-7338 Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective June 25, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at 225. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at 314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at 323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Estates At Delano Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 2, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to

conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is

unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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 PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 September 2, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 2, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145

> St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health Email: kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 07/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245336	B. WING _		06/	02/2017	
	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE	
F 000	conducted by surved Department of Heat Delano was found to the regulations at 4 requirements for Low The survey resulted (IJ) at F225 when the appropriate action was provide resident provide residents regarding staff on appropriate abuse and handling staff on appropriate abuse and handling abuse. An extended survey on 6/1/17 and 6/2/1 The facility's plan or as your allegation of Department's accept enrolled in ePOC, yet the bottom of the form. Your electronic be used as verificated. Upon receipt of an anon-site revisit of your staff on the provide revisit of your provident provide	Ith (MDH). The Estates at o not be in compliance with 2 CFR Part 483, subpart B, ong Term Care Facilities. It in an Immediate Jeopardy the facility failed to ensure was taken to immediately offection and thoroughly I allegations of abuse, which potential for serious harm. 2/17, and was removed on when the facility implemented the included conducting ions for R15, screening of all any abuse, and educating and timely identification of the offers of the CMS-2567 is submission of the POC will cition of compliance. In the conducted to the conducted to a cacceptable electronic POC, an aur facility will be conducted to	F 00	,			
ARODATOR	regulations has bee	ntial compliance with the en attained in accordance with DER/SUPPLIER REPRESENTATIVE'S SIGN	JATUDE	TITLE		(X6) DATE	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

06/29/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245336	B. WING _		06	6/02/2017	
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F 000 F 157	your verification. 483.10(g)(14) NOT	IFY OF CHANGES	F 00 F 15			7/12/17	
SS=D	(g)(14) Notification (i) A facility must improper consult with the responsistent with his representative(s) where the consistent with his representative(s) where the consistent with his representative(s) where the consistent in the consults in injury and physician intervention. (B) A significant charmental, or psychost deterioration in heast the complication. (C) A need to alter a need to discontinuity the commence and the c	of Changes. Immediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or					
	(14)(i) of this sectionall pertinent information	n, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the					
		t also promptly notify the sident representative, if any,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 433 COUNTY ROAD 30 DELANO, MN 55328		·	
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F 157	as specified in §48 (B) A change in restate law or regular (e)(10) of this section (iv) The facility multiple in the address phone number of the transfer of	om or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph	F 15	,	f or dusions Plan of ed as a quality cable ements. acility ms on ate ty of on pleted been	
	non-blanchable red usually over a bon measuring 2 centir	ulcer (intact skin with dness of a localized area y prominence) on the right heel meters (cm) x 2 cm. The note blister. The assessment also		had room changes in past 60 days completed to ensure room change notification has been given. Room/Roommate change Policy re with residents at resident council or	eviewed	

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	PROVIDER OR SUPPLIE			4	STREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 DELANO, MN 55328		
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F 157	identified a Stage thickness loss of open ulcer with a slough. May also open/ruptured bliscm x 1 cm x 0.3 cinclude any further ulcers, intervention treatment initiated. R18's medical receptive physician was not of R18's skin. On 6/2/17, at 11:3 was left for R18's p.m., via telephone was not aware R1 pressure ulcers. I would expect to be developed pressure treatment. LACK OF NOTIC R12's significant of (MDS) dated 5/2/cognitive impairm on staff for transfer puring interview of responsible party, R12 had changed months and she with prior to it happeni liked to had been showing up to the finding R12 not in	2 pressure ulcer (partial dermis presenting as a shallow red-pink wound bed without present as an intact or ster) to the left heel measuring 2 m. The assessment did not or description of the pressure ns, physician notification or	F1	157	6/27/2017. c. Policy and procedure for physic notification of change reviewed and remains current. All licensed nursing will be provided education regarding notification of physician on change conditions. Policy and procedure for Room/Roommate change reviewed remains current. Education to Sociate segarding Room/Roommate change policy. d. Director of Nursing or designed complete an audit on 5 residents Waskin inspection to ensure no new slissues have been identified and if rephysician update was performed. Services or designee to complete a of all residents that were issued room changes to ensure they were proper notified of the room change. Audits occur weekly times 4, monthly time and audit results will be reported to committee for further review and recommendations.	ng staff g in or d and ial ite e to /eekly kin noted a Social an audit om erly s will es 2	

here [nursing home] to home."

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	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	Communation Fa		F 15	7		
	census information in 1/17. R12's med	tronic medical record (EMR) identified R12 changed rooms lical record was reviewed and e FM-A was told of the room ccurring.				
	licensed social work reviewed R12's me locate any documed responsible party has change, "I didn't find FM-A should have I knows where to find a situation to wonder	on 6/2/17, at 8:54 a.m. ker (LSW)-A stated she dical record and was unable to ntation demonstrating R12's ad been notified of the room d any." Further, LSW-A stated been notified so, "The family d them," and are not placed in er, "Where did my loved one t come visit as happened to				
	at the time of room 12/1/16, identified a receive written notion room or room mate changed." The poli staff to provide notion her legal representa	m Relocation policy (in effect change for R12) dated a resident, "has the right to ce before the resident's in the Living Center is cy directed social services ce to the resident, "and his or ative or interested family ten notice and documenting in "				
	and not received.	ion of change was requested 2) NOTICE OF BED-HOLD JPON TRANSFR	F 20	5		7/12/17
	(d) Notice of bed-ho	old policy and return-				
	(1) Notice before tra	ansfer. Before a nursing facility				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	, 00/02/2	•	
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F 205	transfers a resident goes on therapeutic must provide writter resident representation. (i) The duration of any, during which the treturn and resume facility; (ii) The reserve been plan, under § 447.4 (iii) The nursing fact bed-hold periods, where paragraph (c)(5) of the resident to return; and the transfer of a resident the resident and written notice which bed-hold policy desting section. This REQUIREME by: Based on interview facility failed to enspolicy was provided for 2 of 5 residents admission, transfer Findings include:	t to a hospital or the resident c leave, the nursing facility in information to the resident or ative that specifies- the state bed-hold policy, if he resident is permitted to residence in the nursing d payment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with this section, permitting a	F 20	F 205 a. R 79 and R 16 were transferred hospital without proper bed hold. Reviewed the bed hold policy with responsible party of R 79 and R 1 6/29/2017. b. Audit of all residents that have transferred to the hospital in past	the 6 on e been		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245336	B. WING	<u> </u>	06/	02/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 205	4/27/17, identified impairment and was transfers. When interviewed responsible party a stated R79 was renursing home. FM provided any type on ursing home regaladding, "I never know R79's progress not identified R79 was 5/23/17, on an empactivity and readming 5/27/17 (four days lacked any evidence facility bed hold por R79's medical recomposition and provided written not policy with 24 hour required. When interviewed licensed practical recomposition process for sending LPN-A stated staff medication list, have a bed hold stated staff was expolicy notice signer the time of transfer During interview or social worker (LSV)	R79 had severe cognitive as dependent on staff for on 5/30/17, at 2:22 p.m. R79's and family member (FM)-C cently hospitalized from the I-C stated she was not of written notice from the arding their bed hold policy lew there was a policy." Ites dated 5/21/17, to 5/28/17, transferred to the hospital on ergent basis due to seizure litted to the nursing home on later). The progress notes be FM-C had been told of the licy either in writing or verbally. Ord was reviewed and lacked vidence FM-C had been office of the facility bed hold so f R79's hospital transfer as on 6/1/17, at 8:19 a.m. hurse (LPN)-A reviewed the g someone to the hospital. Was supposed to print a vera physician order and also, sheet for them to sign." LPN-A repected to get the bed hold d by family or the resident at	F 205	completed to ensure proper be policy has been given. Bed he reviewed at resident council or and with every new admission. c. Policy and procedure of Bed Policy for Hospital Transfer and Therapeutic Leave policy revier remains current. All licensed rewill be educated on the Bed-Hefor Hospital Transfer and Therapeutic Services or Designed complete weekly audit of all retransferred to the hospital to exproper bed hold has been give will occur weekly times 4, mon and audit results will be reported committee for further review at recommendations.	old policy in 6/27/2017 ed-Hold dewed and nursing staff old Policy apeutic ee to sidents insure en. Audits thly times 2 ed to QAPI		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION			E SURVEY PLETED
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F 205	when they transfe she reviewed R79 unable to locate a provided one and Further, LSW-A si was important to a may be discharge or may continue to for the bed hold a R16's quarterly M 1/4/17, indicated himpaired, and total transfers. Review of the hos revealed that R16 for pneumonia an R16's nursing proindicated R16 was Futher review of the hospital admis notice of bed hold resident. During an interview of the hold resident. During an interview of the hold policy was discharge to the hold policy was discharge to the hold at the facility to survey, and confirmation of the properties of a bed A facility Bed-Hold A facility Bed-Hold appropriate to the hold policy was discharge to the hold at the facility to survey, and confirmation of the properties of a bed A facility Bed-Hold A facility Bed-Hold	r to the hospital. LSW-A stated o's medical record and was ny evidence FM-C had been stated, "not that I can find." tated a signed bed hold notice acquire, as without it residents delsewhere from the hospital obe billed by the nursing home gainst their wishes. inimum Data Set (MDS) dated R16 was severely, cognitively ally dependent upon staff for spital discharge summary was transferred to the hospital deventually admitted. gress note dated 5/29/17, as transferred to the hospital. The progress notes 10 days past sion did not indicate that a was given to the family or the with family member (FM)-2 of a.m., FM-2 confirmed that a has not given at the time of hospital. FM-2 was observed to ovisit R16 every day of the med a daily visit with R16. The foliop for Hospital Transfer eave dated 12/16 identified it	F 2	205			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245336	B. WING		06/	/02/2017
	PROVIDER OR SUPPLIER	_c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE
F 205	resident representativerbally and in writinospital transfers, if and return." The partner responsible partner bed-hold policy," that acknowledge receiprocedures for retuidentified staff should progress notes. 483.12(a)(3)(4)(c)(cy to, "inform the resident, ative and/or responsible party ing of the policies regarding therapeutic leave, discharge policy directed staff to contact try and, "remind them of the en, "A form is provided to pt of the bed hold policies and irn." Further, the policy all document this in the	F 2			7/12/17
SS=J	483.12(a) The facil (3) Not employ or of who- (i) Have been found exploitation, misap mistreatment by a find	otherwise engage individuals d guilty of abuse, neglect, propriation of property, or court of law; ing entered into the State				
	exploitation, mistre misappropriation of (iii) Have a disciplir or her professional body as a result of exploitation, mistre misappropriation of (4) Report to the Stilicensing authorities actions by a court of	nary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	_c		43	REET ADDRESS, CITY, STATE, ZIP CODE 3 COUNTY ROAD 30 ELANO, MN 55328	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	nurse aide or other (c) In response to a exploitation, or mis (1) Ensure that all a abuse, neglect, expincluding injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injurithe events that cau abuse and do not rethe administrator of officials (including the adult protective serfor jurisdiction in logaccordance with St procedures. (2) Have evidence thoroughly investigation of the serious procedures.	facility staff. allegations of abuse, neglect, treatment, the facility must: alleged violations involving ploitation or mistreatment, funknown source and fresident property, are ely, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established that all alleged violations are ated. potential abuse, neglect, treatment while the		225	DEFICIENCY		
	administrator or his representative and with State law, including Agency, within 5 we if the alleged violatic corrective action mathis REQUIREMED by:	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate			F 225		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/0	ZZZ
THE EST	TATES AT DELANO LI	.c			33 COUNTY ROAD 30 ELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 225	review, the facility fabuse were identificated and thoroughly investigated and facility potential verification and facility potential verification and facility administ (DON), and facility notified of the IJ for 6/2/17, at 3:56 p.m remained at the low which is isolated with minimal harm. Findings include: R15's admission rerection and sacral quarterly Minimum indicated R15 was express ideas and non-verbally, make also able to underscomprehension.	ailed to ensure allegations of ed timely, appropriate action ly provide resident protection estigate the allegations for 1 of esulting in high potential for ed in an immediate jeopardy her, the facility failed to report of a fall, requiring sutures, when are plan, for 1 of 2 residents	F 2	2225	a. R 15 allegations were thorough investigated per policy. b. Residents educated during Res Council on 6/27/2017 on their rights responsibilities of being in a safe environment and their rights regard Abuse Prevention/Vulnerable Adult All residents were interviewed to enthat they felt safe in the environmenall abuse allegations were investigation thoroughly. c. Policy and procedure for Abuse Prevention/Vulnerable Adult Plan previewed and remains current. All swere educated to the Abuse Prevention/Vulnerable Adult Plan. Education on completing a thoroug investigation completed administration director of nursing, social services, assistant director of nursing. d. Administrator or Designee will complete an audit with 3 random residents, via interview, to ensure the feel safe in the facility and abuse allegations are investigated timely at thoroughly. Audits will occur weekly 4, monthly times 2 and audit results reported to QAPI committee for furtive wand recommendations. a. R24's fall was investigated and determined that the care plan was followed at the time of the fall. b. All falls since survey exit were at to ensure care plan was followed at time of the fall. c. Policy and procedure for Asses Falls and their Causes reviewed and	sident s and ing the Plan. Issure intended a colicy staff the cor, and in ey	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	_C		43	REET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 ELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 mobility and transfers. During observation on 5/30/17, at 12:22 p.m. R15 was positioned lying in her bed, in her room, with the head of bed slightly elevated. During interview, at 12:35 p.m. R15 stated she had been abused, "emotionally," by staff. R15 stated she had been yelled at and frequently overheard a nursing assistant (NA)-C yell at other residents during the evening shift. R15 stated an altercation had occurred on 5/2/17, in which NA-C and NA-B came into her room to reposition her one evening after putting on the call light. R15 stated there was a board in her room for the NA staff to document time when last repositioned, but there was no current time written on the board. R15 explained she wanted to know the last time she was repositioned. R15 stated she asked when she had last been repositioned and NA-C told her the time. R15 asked NA-C to clarify the time and NA-C immediately raised her voice, became upset, and told R15 she was not listening. R15 stated she was unable to articulate her question of the repositioning time to NA-C, and NA-C, "got progressively louder." R15 stated the asked NA-C, "not to yell," at her and NA-C replied, "I'm not yelling, but if you want me to yell, I can yell." R15 stated she called NA-C "a bitch," and NA-C replied, "I'm not being a bitch, but I can be." R15 told NA-C she was, "going to write you up." R15 mentioned she did not know NA-C's last name, and as NA-C left the room, she loudly spelled out her last name, letter by letter. R15 stated NA-C later returned to the room with a grievance form, with NA-C's name spelled out, and handed it to me stating, "in case		F 2	225	remains up-to-date. Education to a licensed nursing staff on policy and overview of falls and ensuring care followed at the time of a fall and procedure for notification if care planot being followed. d. Director of Nursing or designed complete an audit of a random sele of residents to ensuring care plan is followed at the time of a fall and procedure for notification if care planot being followed. Audits will occuve kly times 4, monthly times 2 and results will be reported to QAPI corfor further review and recommendations.	plan is an is ection s an is an is ur d audit nmittee	

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245336	B. WING _		06	/02/2017		
			STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	•			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE			(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
15 continued the lentified and confiss altercation as as in her room and incident. R15 states rievance form to as concerned abovents and wanted 15 stated during A-C left the room at, NA-C, "can gresented the survivat was partially of the east of the east of the exactly right." In as afraid of retall ischarge notice if 15 stated since to 15 stated she has a lembers talking a shich she emphasion thereof her as well without the 15 stated she has a lember talking a shich she emphasion thereof her as well without the 15 stated she has a lember talking a shich she emphasion the red her as well without the 15 stated she has a lember talking a shich she emphasion the red her as well without the red her as well wit	interview and verbally firmed the nursing assistant in NA-C, and also stated NA-B and witnessed the entire ed she had not turned in the administration yet, because she tout the sequencing of the doto ensure it was accurate. The altercation on 5/2/17, after a lot worse, be careful." R15 years a form titled, Grievance, completed. R15 stated she on 5/2/17, after the altercation at each ensure it was detailed enough. The post if I don't get additional R15 identified she additional R15 identified she attended to the ensure it was detailed enough. The post if I don't get additional R15 identified she attended to the ensure it was detailed enough. The post if I don't get additional R15 identified she attended to the ensure it was detailed enough. The ensure it was detailed enough. The post if I don't get additional R15 identified she attended to the complained. The altercation occurred on the ensurement of the ensurement o		5				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From p 1.5 continued the lentified and conf nis altercation as ras in her room a ricident. R15 state rievance form to ras concerned ab vents and wanted 1.5 stated during A-C left the room rat, NA-C, "can g resented the survivat was partially of egan filling it out ut wanted to make 1.5 stated she ke her head and, "laused and stated exactly right." In ras afraid of retall aused and stated exactly right." In ras afraid of retall sischarge notice if 1.5 stated since to 1.2/17, no other so can come to talk to 1.2/17, between her realtercation with 1.5 stated she has realtercation with	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 12 15 continued the interview and verbally lentified and confirmed the nursing assistant in his altercation as NA-C, and also stated NA-B has in her room and witnessed the entire licident. R15 stated she had not turned in the rievance form to administration yet, because she has concerned about the sequencing of the vents and wanted to ensure it was accurate. 15 stated during the altercation on 5/2/17, after A-C left the room, NA-B verbally stated to her hat, NA-C, "can get a lot worse, be careful." R15 resented the surveyor a form titled, Grievance, hat was partially completed. R15 stated she legan filling it out on 5/2/17, after the altercation but wanted to make sure it was detailed enough. 15 stated she kept thinking about the altercation of her head and, "I just messed up." R15 then haused and stated, "How can I report if I don't get exactly right." In additional R15 identified she has afraid of retaliation that she may be given a ischarge notice if she complained. 15 stated since the altercation occurred on (2/17, no other staff, including the DON, bensed social worker (LSW), or administrator, and come to talk to her about the altercation on (2/17, between herself and NA-C. R15 stated he altercation with NA-C "made me feel terrible." 15 stated she had overheard several other staff inchembers talking about the altercation on 5/2/17, hetween herself and NA-C. R15 stated other as well. Adding, after the altercation PN-A told her NA-C had a "bad temper." urther, R15 stated she felt, "no one is ever held occuntable," at the facility and she questioned if,	DENTIFICATION NUMBER: 245336 A. BUILDIN 245336 B. WING	Dentification number: 245336 245336 245336 245336 245336 245336 245336 245336 245336 245336 25700000000000000000000000000000000000	DIMER OR SUPPLIER ES AT DELANO LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 12 15 continued the interview and verbally entitled and confirmed the nursing assistant in its altercation as NA-C, and also stated NA-B as in her room and witnessed the entire cident. R15 stated she had not turned in the rievance form to administration yet, because she as concerned about the sequencing of the wents and wanted to ensure it was accurate. 15 stated during the altercation on 5/2/17, after A-C. left the room, NA-B verbally stated to her lat, NA-C, "can get a lot worse, be careful." R15 resented the surveyor a form tilled, Grievance, at was partially completed. R15 stated she egan filling it out on 5/2/17, after the altercation ut wanted to make sure it was detailed enough. 15 stated she kept thinking about the altercation ther head and, "l just messed up." R15 then aused and stated. "How can I report if I don't get exactly right." In additional R15 identified she as afraid of retailation that she may be given a scharge notice if she complained. 15 stated since the altercation oncurred on (2/17, no other staff, including the DON, enseed social worker (LSW), or administrator, ad come to talk to her about the altercation on (2/17, pother staff), including after the altercation on (2/17, between herself and NA-C. R15 stated she later as well. Adding, after the altercation on (2/17, between herself and NA-C. R15 stated she felt, "no one is ever held countable," at the facility and she questioned if, the countable," at the facility and she questioned if,		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245336	B. WING _		06	/02/2017		
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP 433 COUNTY ROAD 30 DELANO, MN 55328				
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F 225	upset by this, as shifthe attempt at disc. Ombudsman involvappeal for the faciliaction, and the disc. When interviewed stated she recalled and R15 which hap NA-C and R15 had repositioning when at her. NA-B stated NA-C make her point, an regroup. NA-B stated nurse, but was unanurse was when quere when interviewed stated she recalled R15 on 5/2/17, and working on the san incident she also re DON, but could not reported it. NA-C sand NA-B about redid not believe their been last reposition cussed at the aides NA-C stated she wanswer about her redid not with her not to the resident bed difficult to spell." Naticking bitch." NATIC is spell." Naticking bitch."	R15 stated she continued to be the had not come to terms with harge. R15 stated she got the wed, who assisted in filing an ity's "emergency discharge" charge was rescinded. on 5/30/17, at 3:49 p.m. NA-B the altercation between NA-C opened on 5/2/17. NA-B stated argued about her turning and R15 accused NA-C of "yelling" d they were, "stating a fact." tried repeatedly to verbally d walked out of the room to ted she reported the event to a able to remember who the	F 23	25				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 225	During a subseque p.m. R15 again ex occurred when R1. R15 stated the inci around 7:00 or 8:0 and R15 repeated of time she was lyi and the need for rethe altercation as a went back and forthow R15 felt in NA stated, "nervous an ot like how the incand stated, "I felt the R15's progress not (RN)-A at 21:42 (9 [nursing assistant that when staff me resident, Resident repo [repositioning res [resident] that sand repositioned reat time of reporting scheduling is on tir argumentative with assured res that share you arguing wi Staff member state only told you what you yelling at me, y stated she was not another staff mem NAR reporting state to become calm ar increasingly agitate	ent interview on 5/31/17, at 4:07 plained the altercation that 5 alleged abuse by facility staff. dent happened on 5/2/17, 0 p.m., after the evening meal, her concerns about the lengthing in bed in the same position epositioning. R15 described an argument with NA-C that he and escalated. When asked -C's presence now, R15 added she did cident on 5/2/17, made her feel, preatened that night." It de dated 5/2/17, authored by 1/42 p.m.) indicated, "NAR registered] reported to writer mber went to reposition began questioning NAR about 1/2 scheduling. NAR explained to she had just began her shift es when she arrived and now, to writer, prior to eve meal	F 22	5				

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245336	B. WING		06/0	2/2017		
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(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 225	Continued From pa	age 15	F 22	5				
	licensed practical r "Resident will not a when it was time to Review of R15's pr 5/31/17, lacked ad	rogress notes from 5/2/17 to ditional investigation and he altercation on 5/2/17, or any						
	were reviewed, and NA-C was sch 5/2, 5/4, 5/6, 5/7, 5/5/22, 5/23, 5/25, 5/6 NA-B was sch 5/2, 5/5, 5/5, 5/6, 5/7, 5/6	ules from 5/1/17 to 5/31/17 d indicated the following: eduled on the following days: 5/8, 5/9, 5/13, 5/14, 5/16, 5/19, 1/26, 5/30, and 5/31/17. eduled on the following days: 5/10, 5/11, 5/12, 5/15, 5/16, 20, 5/24, 5/25, 5/26, and						
	DON discussed the on 5/2/17, between stated the first time between R15 and (5/25/17) when NA stated no staff merher. When surveys "emotionally abuse that was the first "I DON reviewed the acknowledged she R15 since the incident have someone DON stated that has would have talked the resident, "This	on 5/31/17, at 5:02 p.m. the e altercation which occurred in R15 and NA-C. The DON e she learned of the altercation NA-C was "last Thursday" a-C approached her. The DON inber had immediately called or reported R15 felt she was ed" the DON reacted and stated have heard about this." The progress notes and it did not see any follow up with dent, and also stated she did talk to the resident (R15). The ead she read the note, she to the nursing assistants and is what we used to do all the inded she was unaware NA-C						

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F 225	allegedly signed, or grievance form ab stated had she knipulled NA-C off the investigation, and resident. The DO 24/7". The DON's did not take it furth somehow she miss. During interview or administrator state explained to him. had a difficult time recently had a roof feelings toward him R15's incident on there might have a between R15 and understanding the administrator state NA-C, but, "I would her side of the the stated they would the allegation on leand replace them, during their investis stated he would deregarding dignity," During a subsequence of the stated we would "I was a subsequence of the stated with R15, was a subsequence of the stated we would "I when interviewed the interviewed would "I was a subsequence of the stated we would "I was a subseque	dated and handed R15 a out the incident. The DON own about this, she would have e floor, pending an also would have talked to the N stated, "Call me, I'm on call stated she talked to NA-C but her. She further stated	F 2	225			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 225	245336 F PROVIDER OR SUPPLIER STATES AT DELANO LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		Fí	225				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 225	with R15. RN-A state emotional or verbaresident felt safe. I document the second R15, and this behas tated [NA-C] "was then. RN-A stated and did not feel and or DON about this." Although the facility between R15 and inaction to fully ided day and subsequents afety of R15 immediate and failed to thorout to make a determininvestigation compabuse, nor did the as identified by the The immediate jeonemoved on 6/2/17 implemented a remand reported Agency; -placed alleged state outcome of the investment of the investm	atted R15 never mentioned I abuse, however, stated the RN-A stated she did not and conversation she had with a vior was typical for R15. RN-A is a favorite" for R15 up until she took no further actions, y need to call the administrator incident. As a favorite for R15 up until she took no further actions, y need to call the administrator incident. As a favorite for R15 up until she took no further actions, y acknowledged the altercation NA-C on 5/2/17, the facility's entify R15's potential abuse that ntly take steps to ensure the ediately pending any finding, ughly investigate the complaint nation. There was no letted to determine possible facility protect other residents facility protect other residents facility policy. Pardy which began 5/2/17, was at 3:56 p.m. after the facility noval plan which included: with R15, revised the plan of the allegation to the State		5				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CO	(X3) DATE SURVEY COMPLETED	
245336 B. WING	6/02/2017	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT DELANO LLC STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225 Continued From page 19 provision to audit staff, and interview residents to ensure appropriate care is providedAdditionally, the administrator indicated, residents and/or family will be asked about any concerns of potential abuse during care conferences. The facility policy, Abuse Prevention/Vulnerable Adult Plan, revised 4/17, indicated in the Response/Reporting section that "All Staff was responsible for reporting any situation that is considered abuse or neglect." The policy indicated, "The unit nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation. Immediately, upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incident of misconduct or injury while the matter is being investigated." Further, "The Nurse will also ensure that any potential for further abuse is eliminated by taking one of the following actions: if this is staff to resident abuse, the staff person will be excused from position until the investigation is completed." The policy directed, when abuse or neglect was alleged or suspected, appropriate corrective action would be taken and notification procedures would be initiated, which indicated "suspected abuse shall be reported to the administrator immediately and OHFC (the State Agency) online reporting process not later than 2 hours after forming the suspicion of abuse." An investigation would begin immediately, led by the investigation team. The investigation may include "interviewing staff, residents, or other witnesses		

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F 225	of procedure, traini staff, etc.)" R24's annual MDS had severe cognitive identified R24 need bed mobility, transfidentified diagnose dementia and anxieth had two or more far assessment dated R24's care plan revenue had a potential for included use of me resulting in an intrain impaired mobility placing him at high identified R24 had since the initial fall. bedside was listed undated Group D needs in training the since the initial fall.	dated 4/19/17, indicated R24 re impairment. The MDS led extensive assistance for er and ambulation. The MDS s of hypertension, arthritis, ety. The MDS indicated R24 lls without injury since the last	F 22	,			
	indicated R24's bed and staff found him	ted 5/11/17, at 3:13 a.m. d alarm went off at 1:20 a.m. lying on his stomach "on the ood. The blood was coming n his head.					
		oom discharge report dated he resident received seven aceration.					
		on 5/31/17, at 7:37 p.m. R24 shout a fall mat on the floor by					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 225	stated the fall mat we the fall mat and was then left the room a resident. No floor resident. No floor resident. No floor resident. During interview on medication aid (TM have a fall matt at he decided the fall dated 5/11/1 as if the fall mat was the fall as care planshe did not realize the progress note the floor and not on his to look for the fall in not completed and regarding the fall on when reviewing fall interventions the fall always reviewed, a know the investigat The DON stated the prior to the fall were if the staff were not 5/11/17, the fall shot state agency and the facility policy. The facility Abuse Felan dated 4/17, dienter the staff were not facility Abuse Felan dated 4/17, dienter the staff were facility Abuse Felan dated 4/17, dienter the staff was facility Abuse Felan dated 4/17, dienter the staff was facility Abuse Felan dated 4/17, dienter the facility Abuse Felan dated 4/17, dienter th	5/31/17, at 7:56 p.m. NA-H was not on the floor, looked for s unable to locate it. NA-H and went to help another mat was placed by R24's 5/31/17, at 8:06 p.m. trained A)-A stated R24 needed to	F 23	25			

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F 226 F 226 SS=F	483.12(b)(1)-(3), 4		F 2:			7/12/17	
	483.12 (b) The facility mus written policies and	st develop and implement I procedures that:					
		event abuse, neglect, and dents and misappropriation of					
	(2) Establish policion investigate any suc	es and procedures to ch allegations, and					
	(3) Include training §483.95,	as required at paragraph					
	the freedom from a requirements in § 4	and exploitation. In addition to abuse, neglect, and exploitation 483.12, facilities must also their staff that at a minimum					
		t constitute abuse, neglect, isappropriation of resident th at § 483.12.					
		for reporting incidents of abuse, n, or the misappropriation of					
	prevention. This REQUIREME	anagement and resident abuse NT is not met as evidenced					
		tion, interview and document failed to implement policies and		F 226			

CLIVILI	TO I OIL WILDICAILE	. A MEDICAID SERVICES			OI	VID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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				4:	33 COUNTY ROAD 30		
THE EST	ATES AT DELANO LI	.C		D	ELANO, MN 55328		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
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F 226	Continued From pa	ae 23	F:	226			
		se prohibition to include		-20	a. R 15 allegations were thorough	alv	
		g of allegations of abuse and			investigated per policy.	ıı y	
		to protect residents during			b. Residents educated during Res	sident	
		nd thoroughly investigate 1 of			Council on 6/27/2017 on their rights		
		llegations of abuse. Further,			responsibilities of being in a safe		
		report to the State Agency a			environment and their rights regard	ing the	
	fall with injuries as	a result of not following the			Abuse Prevention/Vulnerable Adult	Plan.	
		2 residents (R24) reviewed for			All residents were interviewed to er		
		d potential to affect all 35			that they felt safe in the environmen		
		n the facility and resulted in			all abuse allegations were investiga	ited	
		of care (SQC) under the			thoroughly.		
		and Facility Practices due to			c. Policy and procedure for Abuse		
	protect residents fro	to report, investigate and			Prevention/Vulnerable Adult Plan pereviewed and remains current. All	•	
	protect residents in	on futuel abuse.			were educated to the Abuse	stan	
	Findings include:				Prevention/Vulnerable Adult Plan.		
	i mamga malada.				Education on completing a thoroug	h	
	The facility policy, A	Abuse Prevention/Vulnerable			investigation completed administration		
		4/17, indicated in the			director of nursing, social services,		
		g section that "All Staff was			assistant director of nursing.		
		orting any situation that is			d. Administrator or Designee will		
		or neglect." The policy			complete an audit with 3 random		
		nurse will be notified			residents, via interview, to ensure the	ney	
		s the situation to determine if			feel safe in the facility and abuse	d	
	, ,	atment or action is required,			allegations are investigated timely a		
	and complete an in				thoroughly. Audits will occur weekl		
		learning of the incident, staff steps to protect residents			4, monthly times 2 and audit results reported to QAPI committee for further		
		equent incident of misconduct			review and recommendations.	11101	
		natter is being investigated."			131.31 and 1333mmondations.		
		e will also ensure that any			a. R24 s fall was investigated an	d it	
		abuse is eliminated by taking			was determined that the care plan		
		actions: if this is staff to			followed at the time of the fall.		
	resident abuse, the	staff person will be excused			b. All falls were audited to ensure		
	from position until t	he investigation is completed."			plan was followed at the time of the		
					c. Policy and procedure for Asses		
		, when abuse or neglect was			Falls and their Causes reviewed an		
		ed, appropriate corrective			remains up-to-date. Education to a		
	action would be tak	en and notification procedures			licensed nursing staff on policy and		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 433 COUNTY ROAD 30 DELANO, MN 55328	•	-
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F 226	would be initiated, abuse shall be rep immediately and C reporting process forming the suspici investigation would investigation team. "interviewing staff, to the incident" and the investigation wo for procedure, train staff, etc.)" R15's admission re R15 had paraplegide depressive disorder and sacra quarterly Minimum indicated R15 was express ideas and non-verbally, make also able to unders comprehension. Frequired extensive mobility and transform During observation was positioned lying the head of bed sliinterview, at 12:35 abused, "emotional had been yelled at nursing assistant (during the evening altercation had occand NA-B came in one evening after patients."	which indicated "suspected orted to the administrator "HFC (the State Agency) online not later than 2 hours after ion of abuse." The I begin immediately, led by the The investigation may include residents, or other witnesses I "corrective action based on ill be completed (e.g., change ing, discipline or discharge of ecord dated 3/31/17, identified a, anxiety disorder, major er, borderline personality I region pressure ulcers. R15's Data Set (MDS) dated 1/6/17, cognitively intact, able to wants both verbally and e herself understood, and was stand others with clear further, the MDS identified R15 assistance of two staff for bed	F 2	overview of falls and ensurin followed at the time of a fall a procedure for notification if c not being followed. d. Director of Nursing or de complete an audit of a rando of residents to ensuring care followed at the time of a fall a procedure for notification if c not being followed. Audits w weekly times 4, monthly time results will be reported to QA for further review and recom	and are plan is esignee m selection plan is and are plan is ill occur es 2 and audit API committee	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245336	B. WING _		06	3/02/2017	
	PROVIDER OR SUPPLIER	LC	STREET ADDRESS, CITY, STATE, ZIP CO 433 COUNTY ROAD 30 DELANO, MN 55328				
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F 226	there was no curre R15 explained she she was reposition when she had last told her the time. R time and NA-C implecame upset, and listening. R15 state her question of the and NA-C, "got proit went very quick fistated she asked NA-C replied, "I'm to yell, I can yell." bitch," and NA-C rebut I can be." R15 write you up." R15 NA-C's last name, she loudly spelled letter. R15 stated I room with a grieval	nt time written on the board. Wanted to know the last time ed. R15 stated she asked been repositioned and NA-C t15 asked NA-C to clarify the nediately raised her voice, d told R15 she was not ed she was unable to articulate repositioning time to NA-C, ogressively louder." R15 stated from being loud to yelling. R15 JA-C, "not to yell," at her and not yelling, but if you want me R15 stated she called NA-C "a eplied, "I'm not being a bitch, told NA-C she was, "going to mentioned she did not know and as NA-C left the room, but her last name, letter by NA-C later returned to the noce form, with NA-C's name anded it to me stating, "in case	F 22	6			
	identified and confithis altercation as It was in her room are incident. R15 state grievance form to a was concerned above events and wanted R15 stated during It NA-C left the room that, NA-C, "can ge presented the surve that was partially or began filling it out of	interview and verbally rmed the nursing assistant in NA-C, and also stated NA-B and witnessed the entire d she had not turned in the administration yet, because she but the sequencing of the to ensure it was accurate. The altercation on 5/2/17, after NA-B verbally stated to her a lot worse, be careful." R15 eyor a form titled, Grievance, completed. R15 stated she on 5/2/17, after the altercation e sure it was detailed enough.					

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F 226	R15 stated she ker in her head and, "I paused and stated it exactly right." In a was afraid of retalia discharge notice if R15 stated since the 5/2/17, no other stated social work had come to talk to 5/2/17, between he the altercation with R15 stated she had members talking a which she emphas bothered her as we LPN-A told her NAFurther, R15 stated accountable," at the "anyone would do a if she completed the R15 added the addischarge her from was hospitalized. Fupset by this, as shathe attempt at discombudsman involvance and R15 which hap NA-C and R15 had repositioning when at her. NA-B stated NA-C	of thinking about the altercation just messed up." R15 then , "How can I report if I don't get additional R15 identified she ation that she may be given a	F 22	6			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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F 226	regroup. NA-B stanurse, but was unanurse was when quere was when quere was when quere was atted she recalled R15 on 5/2/17, and working on the sar incident she also reported it. NA-C sand NA-B about redid not believe the been last reposition cussed at the aide NA-C stated she wanswer about her reference was an about her reference was a state of the resident bed difficult to spell." NR15 called her a "facknowledged and be a "bitch, but was buring a subseque p.m. R15 again exoccurred when R1 R15 stated the incidence was lying and the need for reference when R1 repeated of time she was lying and the need for reference when R1 repeated of the altercation as a went back and forter was well as went back and forter was well as well	able to remember who the destinated she reported the event to a lable to remember who the destinated. on 5/30/17, at 4:03 p.m. NA-C of the altercation she had with defended had reported it to the nurse me night. NA-C stated after the eported the altercation to the tercall the day and/or time she tated R15 had argued with her positioning. NA-C stated R15 m regarding the times R15 had ned. NA-C stated R15 verbally as and accused her of yelling. The positioning adding she told king my answer." Further, rovided R15 a grievance form the form before giving the ecause "my last name is lated at this time also stated tucking bitch." NA-C also a stated she told R15 she could	F 22	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING			06/	02/2017
	PROVIDER OR SUPPLIE			433	EET ADDRESS, CITY, STATE, ZIP CODE COUNTY ROAD 30 .ANO, MN 55328	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	and stated, "I felt R15's progress no (RN)-A at 21:42 (Inursing assistant that when staff moresident, Resident repo [repositioning res [resident] that and repositioned at time of reporting scheduling is on the argumentative with assured resident that sare you arguing with Staff member stated she was not another staff men NAR reporting stated she was not another staff men NAR reporting stated she was not another staff men NAR reporting stated she was not another staff men NAR reporting state to become calm a increasingly agital bitch. Writer went res is sleeping."	chage 28 threatened that night." Dete dated 5/2/17, authored by 2:42 p.m.) indicated, "NAR registered] reported to writer ember went to reposition to began questioning NAR about go scheduling. NAR explained to she had just began her shift res when she arrived and now, go to writer, prior to eve meal ime. Res became the staff member. Staff member she on time. Res stated 'Why with me, you don't have to yell.' ted, 'I was not yelling or mad, I to I know.' Res replied 'Why are you are a bitch!', staff member of angry or yelling. There was aber, NAR in the room as well. Atted that she will allow res time and return as res was becoming ted and calling Staff member a to res room a while after and colored dated 5/4/17, at time seed practical nurse (LPN)-B ent will not allow [NA-C] into her time to repositioning."	F2	226			
	5/31/17, lacked and documentation of related follow up to Facility staff sche	orogress notes from 5/2/17 to dditional investigation and the altercation on 5/2/17, or any to this occurrence.					
		nd indicated the following:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	5/2, 5/4, 5/6, 5/7, 5/22, 5/23, 5/25, 5 NA-B was sch 5/2, 5/5, 5/6, 5/7, 5/17, 5/18, 5/19, 5/30/17. When interviewed DON discussed the first time between R15 and (5/25/17) when Notated the first time between R15 and (5/25/17) when Notated no staff mether. When survey "emotionally abust that was the first "DON reviewed the acknowledged shoot have someoned DON stated that he would have talked the resident, "This time." The DON allegedly signed, or grievance form at stated had she knowledged NA-C off the investigation, and resident. The DON did not take it furt somehow she missing the state of the pool of the somehow she missing has been seen as the somehow she missing has seen as the somehow she missing has been seen as the somehow she she somehow she missing has been seen as the somehow she she somehow she she she she somehow she	5/8, 5/9, 5/13, 5/14, 5/16, 5/19, 5/26, 5/30, and 5/31/17. neduled on the following days: 5/10, 5/11, 5/12, 5/15, 5/16, 7/20, 5/24, 5/25, 5/26, and If on 5/31/17, at 5:02 p.m. the ne altercation which occurred en R15 and NA-C. The DON nees he learned of the altercation NA-C was "last Thursday" A-C approached her. The DON nember had immediately called for reported R15 felt she was ned the dead and stated the dead and stated and not see any follow up with the dead and see any follow up with the dead and see any follow up with the dead and hand the see and the note, she of the nursing assistants and the see and the note, she and the note of the nursing assistants and the see and the note of the nursing assistant and the nursing assistant	F 2	226			
	administrator state explained to him.	on 5/31/17, at 5:52 p.m. the ed the incident had just been The administrator stated R15 with staff, mentioning that R15					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		245336	B. WING		00	6/02/2017	
	PROVIDER OR SUPPLIER	_C		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328			
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F 226	recently had a roon feelings toward him R15's incident on 5 there might have be between R15 and Nunderstanding they administrator stated NA-C, but, "I would her side of the the stated they would p the allegation on leand replace them, during their investig stated he would do regarding dignity, p During a subseque p.m. the administra with NA-C and sustalked with R15, when ade me feel threastated we would "m When interviewed thad been implement LPN-C stated staff routine training on vulnerable adults a she had not complestated she had not past few days regar abuse, timely reportesident allegations she witnessed or subetween staff and a to be verbal abuse, resident involved an charge nurse or additional states and the states of the state	and the DON. In regard to and the DON. In regard to and the DON. In regard to all and the DON. In regard to all and the DON and it was his a had a disagreement. The did the DON had talked with have to talk to [R15] to get story." The administrator but the staff person involved in ave during the investigation to protect the other residents," gation. The administrator also immediate education attence and resident rights. Int interview on 5/31/17, at 8:02 attence and resident rights. Int interview on 5/31/17, at 8:02 attence and resident rights. Int interview on 5/31/17, at 8:02 attence and resident rights. Into told me "this staff member attened." The administrator make things right for [R15]." Into ensure the IJ removal plan and the on 6/2/17, at 10:43 a.m. was required to complete various topics, including and abuse prevention, however, attenced it yet for the year. LPN-C received any training in the right gold in the reding identification of potential ting of it or how to handle a resident and it had potential as the would visit with the ministration. LPN-C stated if in, nor sure how to handle	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 226	any staff person i as she tried to av LPN-C stated she with residents bef always the nicest around here in genicest." LPN-C s remove or susper allegations of pot as she, "wouldn't further added the to me anyway." Freported concerns past," to the DON A message was leduring the survey not respond to a 1 telephone intervies stated she worker following the alter was sleeping. RN and asked R15 w R15 told her about could provide det with R15. RN-A semotional or verb resident felt safe. document the sec R15, and this beh stated [NA-C] "w then. RN-A stated and did not feel a or DON about this	nvolved in a potential altercation oid, "words with the aides." e had noticed staff interacting fore and, "the tone in itself isn't," further adding, "The tone eneral, by staff, is not always the tated she would not immediately and a staff member who had ential abuse made against them feel authorized to do that," and staff, "probably wouldn't listen urther, LPN-C stated she had a about the tone of staff, "in the land social worker. eft for registered nurse (RN)-A on 6/1/17, at 1:15 p.m. who did telephone call. During a ew on 6/5/17, at 1:16 p.m. RN-A d with R15 on 5/2/17, and reation, checked on R15 but R15 N-A stated she checked back that happened earlier and stated at the incident. However, RN-A ails of the conversation she had tated R15 never mentioned all abuse, however, stated the RN-A stated she did not cond conversation she had with lavior was typical for R15. RN-A as a favorite" for R15 up until I she took no further actions, ny need to call the administrators incident.	F2	226			
	between R15 and inaction to fully id	ity acknowledged the altercation I NA-C on 5/2/17, the facility's dentify R15's potential abuse that					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 226	safety of R15 immediatoroughly investig a determination. The completed to deter the facility protect of the facility policy. The facility Abuse I Plan dated 4/17, diet to the state agency resident care plan. R24's annual MDS had severe cognitive identified R24 need bed mobility, transfidentified diagnose dementia and anxious had two or more factoriculated use of meresulting in an intrain impaired mobility placing him at high identified R24 had since the initial fall. bedside was listed undated Group D ridentified a floor mice. A progress note daindicated R24's beand staff found him.	ediately pending any finding, or ate the circumstances to make here was no investigation mine possible abuse, nor didother residents as identified by Prevention/Vulnerable Adult rected that incidents reported included, not following a dated 4/19/17, indicated R24 we impairment. The MDS ded extensive assistance for fer and ambulation. The MDS in sof hypertension, arthritis, ety. The MDS indicated R24 alls without injury since the last 1/25/17. Vised on 3/8/17, identified R24 falls/accidents. Risk factors edications, pain, a fall 6/14, incranial hemorrhage, resulting and er risk for falls. The care plan fallen several more times as an intervention. R24's hursing assistant sheet at as a safety intervention for a sted 5/11/17, at 3:13 a.m. and alarm went off at 1:20 a.m. and lying on his stomach "on the lood. The blood was coming	F 22	6		

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AND PLAN OF CORRECTION 245336 NAME OF PROVIDER OR SUPPLIER THE ESTATES AT DELANO LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From page 33 R24's emergency room discharge report 5/11/1 indicated the resident received seven sutures to head laceration. During observation on 5/31/17, at 7:37 p.m. R2 was lying in bed without a fall mat on the floor be the bedside. During interview on 5/31/17, at 7:56 p.m. NA-H stated the fall mat was not on the floor as directed. NA-H looked for the fall mat and could not locate it. NA-H then left the room and went help another resident. No floor mat was put by R24's bedside. During interview on 5/31/17, at 8:06 p.m. traine medication aid (TMA)-A stated R24 needed to have a fall mat at his bedside.			STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	•		
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F 226	Continued From pa	age 33	F 22	26		
	indicated the reside					
	was lying in bed wi					
	stated the fall mat directed. NA-H loo not locate it. NA-H help another reside	was not on the floor as ked for the fall mat and could I then left the room and went to				
	medication aid (TM	1A)-A stated R24 needed to				
	DON reviewed the the fall dated 5/11/1 as if the fall mat was the fall as care plans she did not realize the progress note to floor and not his fall look for the fall invecompleted and the regarding the fall owhen reviewing fall interventions the fall ways reviewed, a know the investigated The DON stated the prior to the fall were if the staff were not the fall were if the staff were not the fall were in the staff were not the fall were in t	progress note regarding the 17, and stated it did not look as on the floor at the time of nned. The DON further stated until 6/2/17, while reviewing the resident was found on the ll mat. The DON proceeded to estigation and stated it had not re were no further details in 5/11/17. The DON stated is and implementing new all investigation sheet was not and this was why she did not tion had not been completed. The assessed fall interventions in the expected to be followed and the following the care plan on bould have been reported to the				

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F 226	· •	-	F 226		
F 246 SS=D	facility policy. 483.10(e)(3) REAS	ONABLE ACCOMMODATION RENCES	F 246		7/12/17
		and Dignity. The resident has I with respect and dignity,			
	the facility with reas resident needs and do so would endand resident or other re This REQUIREMEN	eside and receive services in conable accommodation of preferences except when to ger the health or safety of the sidents. NT is not met as evidenced			
	review, the facility for devices were consi was consulted for a	ion, interview and document ailed to ensure hearing stently offered and audiology change in hearing ability for 1) who complained about 19.		F 246 a. R 44 was referred to an audiologis Nursing care guides were updated to reflect need for hearing aids. b. Audit of all residents that have	t.
	4/26/17, identified Fimpairment. Further	num Data Set (MDS) dated R44 had moderate cognitive er, the MDS identified R44 had, with hearing and did not use		hearing aids to ensure proper fit and functionality was completed and referramade as appropriate. Care delivery guides have been updated to reflect nefor hearing aids. c. Education of nursing staff on repor changes in hearing to the charge nurse and following care guides. d. Social Services or designee will	eed
	stated he wanted to hearing problems." hearing aides but d his hearing was, "ki having to "strain mo	5/30/17, at 11:13 a.m. R44 or, "Find out more about my R44 stated he wanted to get idn't know how. R44 stated and getting bad," and he was bre," with his hearing. R44 did des in place during the		complete an audit of 5 residents noted have hearing difficulties to ensure need are met regarding audiology consultation. Audits will occur weekly times 4, month times 2 and audit results will be reported to QAPI committee for further review a recommendations.	ds on. nly ed

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F 246	interview. During subsequent 12:52 p.m. R44 was the hallway. R44 or place. A recent mental he 3/31/17, identified disorder due to a prisited with R44 and the questions I ask you." The note was staff, and lacked as been reviewed. When interviewed nursing assistant (hearing and, "deaff stated she had neval aides, and did not Further, NA-E stated little worse," in the reported to the nuraware of it." During interview or practical nurse (LP has hearing issues aides to her knowled unaware the NA stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated if a resident kept in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated in the medical LPN-A stated in the medical LPN-A stated in the medical LPN-A reviewed the unable to locate ar Further, LPN-A stated in the medical LPN-A stated in the	age 35 tobservation on 5/31/17, at its seated in his wheelchair in lid not have hearing aides in alth Progress Note dated R44 had been seen for a mood ast stroke. The provider id documented, "For most of ited him, he stated 'I can't hear is unsigned by nursing home my evidence hearing issue had on 5/31/17, at 7:48 p.m. NA)-E stated R44 was hard of 'in at least one ear. NA-E iter seen R44 wear hearing use them to her knowledge. Ited R44's hearing seemed, "a past months and this had been ses, "I believe the nurses are in 6/1/17, at 11:46 a.m. licensed in high and noticed R44, "Sometimes," but did not wear any hearing itedge. LPN-A stated she was aff had noticed R44's hearing the past months. LPN-A used hearing aides, they were tion carts so they are not lost, ited the NA staff should be with hearing as, "maybe he	F 24	6		

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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	,	
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F 246	identified R44 had and identified to hal loss." The physicia audiology for hearing completed on 3/15 being identified in half R44's medical recompleted on referred testing. When interviewed assistant director of had a history of be last hearing appoint that long ago." AD hearing aide, howe it. The ADON state hearing aide went, R44's care plan dat risk for impaired vision and hearing to, "Ensure placement."	ic Form dated 2/19/16, been seen by the physician ave, "asymmetrical hearing an provided orders, "May go to ng aids [sic]." This was /16, with no further consults	F 24	6		
	any identified beha aides. During subsequent p.m. ADON stated in the medication removed it from the there. ADON states	eded." The care plan lacked viors regarding his hearing tinterview on 6/1/17, at 1:16 she found R44's hearing aide doom, but was unsure who had be medication cart and placed it d she had just spoken with R44 her with, "I can't hear you," but				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DATE SURVEY COMPLETED
		245336	B. WING		06/02/2017
	PROVIDER OR SUPPLIER	с		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ADON stated staff to offer R44 the heabehaviors adding, "stated the nurses u ordered to ensure the been accidentally recownership changed Further, ADON stat worsening hearing, addressed and a reto, "see if there's are A facility policy on audiology services provided. 483.10(e)(6) RIGHTROOM/ROOM/ROOM/ATROOM/ROOM/ATROOM/ROOM/ATROOM/ROOM/ATROOM/ROOM/ATROOM/ROOM/ATROOM/ROOM/ATROOM/ATROOM/ROOM/ATROOM/A	were still expected to attempt aring aide despite his past We need to try." ADON sed to have a treatment his happened, however, it had emoved when the facility and was not carried over. The different had been afternal made to the audiologist my changes." TO NOTICE BEFORE	F 247		ted

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 433 COUNTY ROAD 30 DELANO, MN 55328		
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F 247	During interview of stated he had a roseveral months at just bring them in liked to have some coming before the R22's progress not identified the follop.m. "[R22] got a happy about this.' having called the and complained to There was no dooprogress notes Right roommate coming R22's medical recany documentation informed of the nearrival in the facilial When interviewed licensed social woused, "Room chawhen they are get LSW-A stated she R22's recent room stated she spoke staff and the documpset, "shows he one." Further, LS way to demonstrate roommate arriving given as much was sure he had time.	on 5/30/17, at 11:33 a.m. R22 commate change within the past and was not notified prior, "[Staff] "." R22 stated he would have e notice of a new roommate ey arrive. Otes dated 3/22/17, to 3/28/17, wing entry on 3/27/17, at 11:46 roommate today, and isn't 'R22 was documented as new roommate several names, o other residents about him. Cumented evidence in the 22 was provided any notice of a g prior to this entry. Cord was reviewed and lacked on to demonstrate R22 had been sew roommate prior to their	F2	Room/Roommate change and remains current. Soc educated regarding Room change policy. d. Administrator or desig an audit of all residents the new roommate for proper Audits will occur weekly tirt times 2 and audit results with to QAPI committee for furt recommendations.	ial services /Roommate nee to complete at received a notification. nes 4, monthly vill be reported	

	/02/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247 Continued From page 39 Change Consent Form," should be signed by the resident who is moving to the new room and, "be introduced to the new roommate and shown the new room, prior to the actual move." The policy lacked any information on how to ensure existing residents were notified of a impending new resident coming and/or roommate change prior to it occurring. F 258 483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a comfortable level of sound in 1 of 1 rooms for 2 of 2 residents (R12, R16) who shared a room and were reviewed for environmental noises. F 258 F 258 F 258 F 258 F 258 F 258 F 258 F 258 F 258 A. The air mattress pump was exchanged for a properly functioning pump for R 12 and maffunctioning pump was taken out of rotation until it can be repaired. b. Audit of all residents that have an air mattress was conducted to ensure prope comfortable, sound level is maintained. c. All staff ble educated on notification to maintenance director on an air mattress that is making noise causing an uncomfortable sound level. d. Maintenance Director or designee to complete an audit on 5 resident rooms to ensure comfortable sound level. d. Maintenance Director or designee to complete an audit on 5 resident rooms to ensure comfortable sound level is maintained. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	У

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		245336	B. WING _		06	/02/2017
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F 258	During observation was sleeping on a I mattress. The matt loud vibrating rumb the bed. The noise level voice, would nopened her eyes withen closed her eyes. During observation was sleeping on he mattress turned on rumbling sound as noise was so loud a would not be possil motor was hanging white wash clothes motor and footrest. During interview on assistant (NA)-H st R12 or R16 slept in mattress turned on couldn't sleep throushe was unsure if thad been reported. During interview on stated the air mattre that way for about the tit had been reported months ago and the was still really loud between the motor footboard were the noise. NA-J stated	on 5/30/17, at 2:17 p.m. R12 Micro Air 65 alternating air ress turned on and created a ling sound as it rattled against was so loud a conversational not be possible to hear. R12 hen the air mattress started as again. on 6/1/17, at 2:22 p.m. R12 r air mattress when the air again making a loud vibrating it rattled against the bed. The a conversational level voice ble to hear. The air mattress at the foot of the bed and had under the hooks between the of the bed. 6/1/17, at 2:23 p.m. nursing ated she was not sure how the room when the air NA-H further stated "I igh that noise." NA-H stated he noise from the air mattress	F 25	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245336	B. WING_		06/	02/2017	
	PROVIDER OR SUPPLIER	_c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	•	-	
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F 258	During the environing p.m. the environment and the administration stated the washold decrease the vibratialso stated a board of the wall to keep help with the noise and R12 could not their cognitive abilitinal mentioned a lobed some time bacair mattress was to mattress switched A policy on monitor none was provided 483.21(b)(3)(i) SEF PROFESSIONAL SEF (b)(3) Comprehens The services provides outlined by the comust- (i) Meet profession This REQUIREME by: Based on interview facility failed to devision integrity issues reviewed for pression Findings include: R18's Admission R	mental tour on 6/1/17, at 2:31 ental services director (ESD) for were present. The ESD the had been placed to tion and the noise. The ESD I had been placed at the base the bed away from the wall, to the administrator stated R16 complain of the noise due to ties but R16's family member and noise coming from R12's ext. The administrator stated the oloud and they would get the out. RVICES PROVIDED MEET STANDARDS Sive Care Plans ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced of and document review the relop an initial care plan for the form of a residents (R18)	F 28		rey exit, care prevent at risk.	7/12/17	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 281	Continued From pa	ge 42 neck of right femur, idiopathic	F 2	81 re-educated on the d	evelopment of an	
	peripheral autonome mobility. R18's Admit/Initial I indicated 18 separated follows: right antecount elbow, left elbow, rileft knee front, right front, left lower legal lower legar, right listed twice, right analyse of skin issue a measurements/desentallyse undated Initiated plan) for skin integrinterventions to minuter on practical nurse (LPI) admitting the resideal areas of the tem	Data Collection dated 3/15/17, ate skin impairment sites as ubital, left antecubital, right ght thigh front, left thigh front, knee rear, right lower leg front, right lower leg rear, left ankle inner, left ankle inner akle outer listed twice, and left sessment did not identify the nd lacked any cription. al Care Plan (temporary care ity did not identify any nimize risk for pressure ulcers. 6/2/17, at 8:23 a.m. licensed N)-C stated the floor nurse ent was responsible to fill out porary care plan.		initial care plan includissues. d. Director of Nursin review a random san admissions for developlans. Audits will occur monthly times 2 and reported to QAPI con review and recomme	ding skin integrity ng or designee will nple of new opment of initial care cur weekly times 4, audit results will be nmittee for further	
	registered nurse (R plan and stated the any interventions.	6/2/17, at 9:20 a.m. N)-A looked at the initial care skin risk area did not have RN-A stated the floor nurses or completing the temporary				
	stated the initial car completed within 24 should have include	6/2/17, at 9:41 a.m. RN-B re plan needed to be 4 hours of admission and ed a skin integrity plan with vent pressure ulcers.				
	During interview on	6/2/17. at 10:24 a.m. the				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING _		06/02/2017	
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	•	
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	identified assessme were an issue and previous week. The expected staff to co A policy on tempora and not received. 483.21(b)(3)(ii) SER PERSONS/PER CA (b)(3) Comprehens The services provide	(DON) stated she had ents and care plans for skin had started re-training staff the DON further stated she emplete temporary care plans. ary care plans was requested RVICES BY QUALIFIED ARE PLAN	F 28			7/12/17
	care. This REQUIREMENT by: Based on observatoreview, the facility for planned intervention residents (R24) reversidents (R75, R2 smoking and/or was failed to follow the promotoring for 1 of pressure ulcers. Findings include: R24's annual Minimal 4/19/17, indicated Firmpairment. The Minimal form the minimal form.	qualified persons in ich resident's written plan of NT is not met as evidenced tion, interview and document ailed to implement care ins to prevent injury for 1 of 2 iewed for falls, and 2 of 2 of 2 iewed for safety with indering. Further, the facility plan of care for wound 3 residents (R44) reviewed for safety with indering. Further, the facility plan of care for wound 3 residents (R44) reviewed for in Data Set (MDS) dated R24 had severe cognitive DS identified diagnoses of tis, dementia and anxiety. The inneeded extensive assistance		a. R 24 care plan was reviewed a updated appropriately for falls. R plan reviewed to reflect proper Wanderguard use and smoking sa 27 care plan was reviewed and upappropriately for smoking safety. It care plan was reviewed and update appropriately for pressure ulcer management. b. Residents who have had a new since survey exit will be reviewed thoroughly to ensure immediate interventions are placed at the time fall to prevent injury and care plans updated with immediate interventions.	75 care fety. R dated R 44 ed v fall	

CLIVILI	TO I OIL MEDICAILE	. & WILDICAID SLIVICES			<u> </u>	IVID INO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING			06/0	02/2017
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				4:	33 COUNTY ROAD 30		
THE EST	ATES AT DELANO LL	.C			ELANO, MN 55328		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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F 282	Continued From page 44			282			
		nsfers, and ambulation and			residents that utilize a Wanderguar	d will	
		two or more falls without injury			be reviewed to ensure Wandergua		
		ssment dated 1/25/17.			are placed and functioning. Care p		
	311100 1110 1431 43363	Sament dated 1/20/11.			updated as indicated. All residents		
	P24's care plan rev	rised on 3/8/17 indicated a					
		rised on 3/8/17, indicated a			smoke will be reviewed to ensure page safety measures are implemented		
		ccidents. Risk factors included					
		, pain, a fall in 6/14, which			prevent injury. All residents who ha		
		nial hemorrhage with impaired			current pressure ulcers will be aud		
		and cognition which placed			ensure weekly wound monitoring is	5	
	_	or falls. The care plan			completed.		
		fallen several more times A fall matt at the bedside was			c. Policy and procedure for Falls		
	listed as a fall interv				Clinical Protocol, Code Alert Wand Monitor System, Resident Smoking		
	listed as a fall interv	vention.				g, and	
	P24's undated Gree	up D nursing assistant shoot			Weekly Charting Wound Ulcer Documentation reviewed and rema	vin	
	included a fall mat.	up D nursing assistant sheet			current. Education to nursing staf		
	inciuded a fail filat.				appropriate policies, and ensuring		
	A progress note da	ted 5/11/17, at 3:13 a.m.			procedures and interventions are u		
		d alarm went off at 1:20 a.m.			per care delivery guides. Falls train		
		lying on his stomach "on the			with all licensed nurses on reviewir		
		ood. The blood was coming					
	from a laceration of				care plan, and determination that or plan is followed at the time of a fall		
	ITOTTI A TACETALION OF	i iliə ildau.			Education to licensed nursing staff		
	During observation	on 5/31/17, at 7:37 p.m. R24			proper monitoring of pressure ulce		
		nere was no fall matt by the			d. Director of Nursing or designed		
	bedside.	lere was no fall mall by the			complete an audit of a random sele		
	bedside.				of resident s that fell for the care		
	During interview on	5/31/17, at 7:56 p.m. nursing			being followed. Social Services or	Jiai i	
		ted the fall matt was not on the			designee will complete an audit of	3	
		A-H looked for the fall matt			residents that utilize a Wanderguar		
		t. NA-H left the room and went			ensuring care plan is being followe		
	to help another resi				Social Services or designee will co		
	to help allother resi	uent.			an audit of all resident s that smol		
	During interview on	5/31/17, at 8:06 p.m. trained			ensure proper interventions are in		
		A)-A stated that R24 needed			and care plan is being followed.		
		at his bedside. TMA-A found					
					of Nursing or designee will comple		
		the door and placed it on the			audit to ensure weekly monitoring		
	floor.				pressure ulcers is completed per c		
					plan. Audits will occur weekly time	54,	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 282	director of nursing information charted didn't sound as if the The DON further stinterventions were WANDERGUARD: R75's admission Manderate cognitive behavior which pla potentially dangeror R75's care plan dated at risk for elopeme leaving the facility awere to have no incremain safe during care plan identified "Wanderguard place" Wanderguard place During observation was outside on the cigarette. R75 did When observed on lying in his bed on clothed. He was whave a Wanderguard located on his beds on the Wanderguard.	in 6/2/17, at 10:33 a.m. the (DON) stated, based on the don the fall dated 5/11/17, it in fall matt was on the floor. It is tated assessed fall expected to be followed. IDS dated 2/21/17, identified a impairment and wandering ced him at risk for getting to a rus place. Ited 2/15/17, indicated R75 was not related to attempts of and wandering. R75's goals cidence of elopement and to placement at the facility. The an intervention of, sed." In on 5/31/17, at 1:33 p.m. R75 smoking patio having a not have a Wanderguard on. In 5/31/17, at 7:17 p.m. R75 was top of the blankets, fully atching television. R75 did not and on. The Wanderguard was side table, however, the band		,			
	stated he used to v wrist, but the band several weeks ago the band had broke	vear a Wanderguard on his on the Wanderguard broke . R75 stated he told the staff en on the Wanderguard, but no given him a new one. R75					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 06/02/2017			
		245336	B. WING					
	PROVIDER OR SUPPLIER TATES AT DELANO LI	_c		STREET ADDRESS, CITY, STATE, ZIP 433 COUNTY ROAD 30 DELANO, MN 55328	•	-		
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F 282	stated sometimes in pants pocket or his When interviewed of TMA-A stated R75 p.m. TMA-A went to Wanderguard sittin stated R75 should and not sitting on the When interviewed stated R75 was an Wanderguard locat interview on 6/1/17 did not wear a Ward When interviewed director of nursing staff to follow a result further stated, not in attached to R75 was care plan. SMOKING: R75's admission M2/21/17, identified in impairment, require activities of daily live any tobacco product Report identified an "Tobacco Use." R75's care plan da "Resident currently included a goal for safely." The care pincluded, "Independent to the state of the same part of the same pant of	ne kept the Wanderguard in his coat pocket, but not always. on 5/31/17, at 7:26 p.m. wore a Wanderguard. At 7:30 or R75's room and found the ground on his bedside table. TMA-A have it attached to his body ne bedside table. on 6/1/17, at 7:54 a.m. NA-K elopement risk and wore a ed on his wheelchair. During, at 8:04 a.m. NA-J stated R75	F 28	2				

245336 B. WING	6/02/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT DELANO LLC STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R75's Smoking Evaluation dated 3/10/17, indicated R75 had cognitive loss and a visual deficit and smoked two to five times per day. The evaluation indicated R75 required adaptive equipment which included a, "Smoking apron." Further, the evaluation indicated R75 was accepting of wearing a smoking apron and accepting of facility smoking times. During observation on 5/30/17, at 1:32 p.m. R75 went outside to the smoking patio in his wheelchair. He had an un-opened smoking apron on his lap. The entire time R75 was smoking, the safety apron remained folded on his lap. There were no staff supervising R75 while he smoked. When observed on 5/31/17, at 1:28 p.m. R75 was sitting by the nurse's station requesting his cigarettes. Staff handed him two cigarettes, his lighter, and a smoking apron. R75 propelled himself outside to the smoking patio. The smoking apron remained folded on his lap. At 1:31 p.m. a nursing assistant (NA)-L went outside to the smoking patio and told R75 he must have his apron on to be outside smoking. NA-L placed the smoking apron on R75 and then went back inside the facility. During interview on 5/31/17, at 1:33 p.m. R75 stated sometimes he wore the smoking apron and sometimes he did not, depending on how he felt. R75 stated he typically just placed the smoking apron on his lap. When interviewed on 5/31/17, at 7:23 p.m. NA-H stated R75 had to wear a smoking apron when he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			43	REET ADDRESS, CITY, STATE, ZIP CODE 3 COUNTY ROAD 30 ELANO, MN 55328	,	
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F 282	staff member to be smoked. During interview of medication aide (Tresidents had to well During interview of practical nurse (LF an apron when he evaluation. LPN-A is supposed to be often just placed it should be wearing neck so it covered just be folded on hor of 6/1/17, at 12:18 (DON) stated she care plan for each stated not using the considered not foll R27's admission M4/3/17, identified mand indicated R27 products. R27's care plan dacurrently smoking R27's care plannersmoke safely." Further ventions included to smoke, "evaluation."	e outside with him when he in 5/31/17, at 7:26 p.m. trained fMA)-A stated for extra safety, ear a smoking apron. In 6/1/17, at 8:35 a.m. licensed PN)-A stated R75 had to wear smoked per his smoking also added the smoking apron worn around his neck, but R75 on his lap. LPN-A stated R75 the smoking apron over his his chest and body and not	F 2	282			

AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245336	B. WING		06/02/2017	
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F 282	Continued From pa	ige 49	F 28	32		
		noking apron [device covering prevent burns from dropped				
	came to the nursing folded up gray color three single cigaret nurse (LPN)-E. R2 using his walker. R smoking apron on a proceeded to light I them. R27 stated them. R27 stated them as is the provide "never questioned in the provide "	on 5/30/17, at 1:34 p.m. R27 g station and was provided a red smoking apron, lighter and tes from licensed practical. Then ambulated outside 27 placed the folded up the table outside and his cigarette(s) and smoke he staff was aware he was not ed smoking apron but had, it." 16/1/17, at 8:52 a.m. nursing ated R27 took the smoking him and staff only assisted him anted it as, "That's up to him." It the smoking apron was, led" though, to reduce the risk				
	assistant director o plans were used to getting their indepe were expected to fo stated R27 should	on 6/1/17, at 12:16 p.m. the f nursing (ADON) stated care, "make sure every resident is ndent needs met," and staff ollow it. The ADON further be using the smoking apron as luation and care plan.				
	LACK OF ADEQUA	ATE WOUND MONITORING:				
	4/26/17, identified I impairment, require activities of daily liv	num Data Set (MDS) dated R44 had moderate cognitive ed extensive assistance with ing (ADLs), had a current as full thickness tissue loss)				

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245336	B. WING		06/02/2017		
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP C 433 COUNTY ROAD 30 DELANO, MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 282	pressure ulcer and ulcer development. R44's care plan data a pressure ulcer duincontinence and litidentified R44 had a ulcer on his buttock complete, "Weekly "Conduct weekly sk During observation licensed practical in R44's dressing charoutinely measure to changes as, "that's LPN-C completed in collection of R44's When interviewed of LPN-C stated she wassigned or respondocument characte LPN-C stated floor pressure ulcer if diretreatment administrative TAR dated 4 staff, "Complete We [Monarch Health M Wound Evaluation] wound." This was a weekly basis on 4 5/17/17, 5/24/17 an 5/3/17, the entry was home," and on 5/10 as, "Drug refused."	remained at risk for pressure remained at risk for pressure and 5/8/17, identified R44 had be to bowel and bladder mited mobility. The care plant a current stage III pressure and directed staff to awound assessment," and, axin inspection." on 6/2/17, at 9:57 a.m. urse (LPN)-C completed ange. LPN-C stated she did not he ulcer with dressing only scheduled or whatever." The measurements/data pressure ulcer. on 6/2/17, at 10:26 a.m. was unaware who was sible to measure and ristics of pressure ulcers. staff only measure the ected to do so by the	F 28	2			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	-	COMPLETED		
		245336	B. WING		_	06/02/2017	
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STA 433 COUNTY ROAD 30 DELANO, MN 55328	TE, ZIP CODE		
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F 282	R44's MHM Weekly 4/30/17, 5/1/17, 5/1 R44 had a stage III Additionally, the evameasurements of the evaluations fur wound clinic. Although data, there was no assessment as directly as as as as directly as	y Wound Evaluation dated 9/17, and 5/30/17 identified pressure ulcer on his coccyx. aluations contained he stage III pressure ulcer. ther identified R44 visited a ugh evaluations contained comprehensive weekly wound ected by the plan of care. In was reviewed. There was mentation identified to pressure ulcer and associated been monitored/assessed on directed by the care plan and to the composition of the floor nurses of measure and document floor in a weekly basis using the measure and stated his pressure tracked weekly, but should attinued monitoring to ensure g," and R44's, "treatment"		82			
			F 3	14			7/12/17
	(b) Skin Integrity - (1) Pressure ulcers comprehensive ass	. Based on the sessment of a resident, the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 314	facility must ensure (i) A resident receive professional stands pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional stands healing, prevent inform developing. This REQUIREME by: Based on observation review, the facility assess pressure ulcers after actual harm. In additional consistently monitor characteristics for reviewed who had Findings include: R18's Admission Residents for the facility on 3/3 included fracture to peripheral autonom mobility. R18 was a chome care on 3/31 R18's hospital discindicated R18's skilled.	ves care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and pressure ulcers receives nt and services, consistent with ards of practice, to promote fection and prevent new ulcers NT is not met as evidenced ation, interview and document failed to comprehensively lcer risk, implement conduct weekly skin monitoring (R18), who developed multiple are admission, resulting in dition, the facility failed to pressure ulcer 1 of 3 residents (R44) a current pressure ulcer.	F 3′	F 314 a. R 18 has been discharged facility on 3/31/2017. R 44 will weekly wound evaluations con b. Audit of all new admission survey exit reviewed to ensure comprehensively assessed for ulcer risk and interventions are implemented to prevent press. Additionally, an audit of weekly monitoring will be completed oresidents with pressure ulcers pressure ulcer characteristics. c. Policy and procedure for V Charting Wound Ulcer Documreviewed and remains current. Management Team will be recomprehensively assessing for ulcer risk and implementing aprinterventions to prevent pressure ulcers. Ecomprevent pressure ulcers. Ecomprevent pressure ulcers.	have npleted. s since they are pressure ure ulcers. wound on all current for Veekly entation Nursing educated on r pressure opropriate ure ulcers. educated on sing followed		

	INO I OIN WILDIOANE	A MEDICAID SERVICES			U	IVID IVO.	0930-0391
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING			06/0	02/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE EG.	TATES AT DELANO LI	C		43	33 COUNTY ROAD 30		
INE ES	IAIES AI DELANO LI	-0		D	ELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	identified 18 separa follows: right antect elbow, left elbow, ri left knee front, right front, left lower leg lower leg rear, right listed twice, right ar ankle outer. The astype of skin impairm measurements. Th any area of concern R18's Tissue Tolera to determine specific course of a specific indicated a lying rept two hours, however determine R18's he resident. The observe commendation for R18's Braden Scale pressure ulcer risk) completed, the ass R18's undated Initiation plan) for skin integinterventions to mir care plan for mobility assist with transfers turn and reposition two hours and as n R18's admission M 3/22/17, did not ided The MDS indicated assistance with bed assistance with bed since the second residual resi	Data Collection dated 3/15/17, ate skin impairment sites as ubital, left antecubital, right ight thigh front, left thigh front, it knee rear, right lower leg front, right lower leg rear, left ankle inner left ankle inner left ankle inner left ankle inner left ankle outer listed twice, and left seessment did not identify the ment and lacked any e assessment did not address in to either of R18's heels. Ance Observation (assessment ic pressure to an area over the left time) dated 3/16/17, positioning schedule of every r; the assessment did not left left pressure as a post surgical right pressure as a lost surgica	F3	314	nursing assistants regarding the re of skin issues they observe during routine daily cares of residents and following interventions to prevent pulcers. Education to licensed nurs on ensuring proper monitoring of pulcers. Director of Nursing or designed will complete a weekly wound evaluation all pressure ulcers for pressure characteristics. d. Director of Nursing or designed review a random sample of new admissions for a comprehensive assessment for pressure ulcer risk been completed and interventions implemented to prevent pressure ulcer Director of Nursing or designee will complete an audit to ensure weekly monitoring of all pressure ulcers is completed on pressure ulcer characteristics. Audits will occur with times 4, monthly times 2 and audit will be reported to QAPI committee further review and recommendation.	their I ressure ing staff ressure gnee uation ulcer e will has are ulcers. I y veekly results e for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245336	B. WING		06	/02/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	pressure ulcers. Trelieving interventi device in bed and the chair. The MD reposition schedul identified use of a fluid). R18's pressure ulcers are extensive assistant frequent bladder a admitted to the fact staples to the right pressure ulcers are The CAA directed skin assessment a Interventions in plareduction mattress was to assist with R18's Skin Evalua Stage 1 pressure unon-blanchable reusually over a bon measuring 2 centified the area also identified the area also identified a Statickness loss of copen ulcer with a relough. May also open/ruptured blis cm x 1 cm x 0.3 crinclude any further	the MDS included pressure ons of a pressure reducing a pressure reducing device in S did not identify a turn and e for R18. The MDS further diuretic (medication to control of the cere Care Area Assessment 17, indicated R18 was at risk to alcers related to a need for of the with bed mobility and not bowel incontinence. R18 cility with surgical incisions with the hip. R18 had no history of the notal current pressure ulcers. Staff to refer to the admission and weekly skin assessment. The ace included a pressure and wheelchair cushion. Staff turning and repositioning. Ition dated 3/29/17, indicated a culcer (intact skin with dness of a localized area by prominence) on the right heel meters (cm) x 2 cm. Staff as a blister. The assessment age 2 pressure ulcer (partial lermis presenting as a shallow red-pink wound bed without present as an intact or ter) to the left heel measuring 2 m. The assessment did not redescription of the pressure	F 3			
	treatment initiated	ns, physician notification or There was no evidence a Skin mpleted the previous week on				

	A. BUILDIN	NG	CON	MPLETED
245336	B. WING _		06/	/02/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT DELANO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	,	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314 Continued From page 55 3/22/17, as the treatment sheet directed, althoug it was initiated as completed. There was no indication of characteristics or interventions identified as part of the assessment. R18's progress notes dated 3/29/17, through discharge on 3/31/17, did not include evidence the physician was notified of the development of two Stage 2 pressure ulcers, nor did the notes identify implementation of interventions or treatments. R18's Doctor Order Sheet dated 3/29/17, did not indicate the physician was notified of the two Stage 2 pressure ulcers. The order included an order to discharge home with home care, but did not include orders to treat pressure ulcers. On 6/1/17, at 12:05 p.m. the licensed dietician (LD)-A stated she had completed R18's Nutritional Assessment on 3/23/17, and reviewed R18's hospital discharge summary, progress notes and nursing assessments, which did not identify any pressure ulcers. LD-A stated she had completed her assessment prior to the skin assessment on 3/29/17, identifying the pressure ulcers. LD-A further stated she was not notified of the pressure ulcers and would expect to be, so protein needs could be re-evaluated and appropriate interventions implemented to promote healing. During interview on 6/2/17, at 8:23 a.m. licensed practical nurse (LPN)-C stated a full skin assessment was required to be completed within 24 hours of admission and then weekly after that	i f	14		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		245336	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	the treatment sheet the assessments. Lassessments were nurse who did the stated if a new pretreatment would be the physician, fami LPN-C stated the fresident was responsive temporary care plated on 6/2/17, at 9:20 looked at the initial risk area did not hat then reviewed the and stated it was becompleted. RN-As responsible for conthe temporary care has time she would assessments. RN-assessments were in the electronic mereviewed the 3/29/stated it indicated I pressure ulcers on physician should he managers to el appropriate and the could be investigat visually inspect R1 MDS and relied on electronic medical. On 6/2/17, at 9:41 told R18 had develulcers on her heels plan needed to be	et was a reminder to complete PN-C further stated the Braden completed by the registered MDS assessment. LPN-C ssure area was identified, a c initiated, along with notifying ly and director of nursing. loor nurse admitting the possible to fill out all areas of the	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	integrity plan with in pressure ulcers. Rivesponsible for con assessment and the complete a full skin the findings on a formation of MDS nurse should were not completed assessments and subsection of nursing identified assessments and previous week. The expectations were an issue and previous week. The expectations were assessments along care plans. DON strage 2 pressures "concern." On 6/2/17, at 11:31 was left for R18's pp.m., via telephone did not have pressure facility and she developed two Stage admission. The phythe facility to implein pressure ulcer and when a resident de order to provide apresulted in actual hallough, the facility reducing mattress admitted to the facility for the facility reducing mattress admitted to the facility for the facility of the facility for th	nterventions to prevent N-B stated the MDS nurse was apleting the Braden e floor nurses were required to a audit weekly and document rm. RN-B further stated the have noticed the assessments d when doing the MDS should have told a supervisor. 16/2/17, at 10:24 a.m. the (DON) stated she had ents and care plans for skin had started re training staff the e DON further stated her timely and complete with completed temporary stated R18 developing two sulcers after admission was a a.m. a telephone message hysician. On 6/5/17, at 1:38, R18's physician stated R18 ure ulcers upon admission to was not made aware R18 had ge 2 pressure ulcers after visician stated she expected ment interventions to prevent would expect to be notified veloped pressure ulcers in propriate treatment. This arm for R18. 19 y implemented a pressure and cushion when R18 lity on 3/15/17, following a	F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING _		06	/02/2017
	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP C 433 COUNTY ROAD 30 DELANO, MN 55328		
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F 314	of pressure ulcer de implement interven development, and results. As a result, is pressures ulcers or following admission resulted in actual harmonic presulted i	evelopment on her heels, tions to prevent pressure ulcer monitor R18's skin on a weekly R18 developed two Stage 2 in their bilateral heels, 14 days in to the nursing home which arm for R18. Wound Process Checklist Notify MD/Treatment as family and/or responsible completed with resident and party including review of risks and weekly wound in 5. Notify nurse manager/omplete new tissue tolerance in the original to the prize to dietary. 9. Refer to interdisciplinary team priate. 11. Update care plan assignment care list. 13. port." The process Checklist Notify MD/Treatment as prize to dietary and prize to manager for the process of the process o	F 31	4		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIF 433 COUNTY ROAD 30 DELANO, MN 55328			
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F 314	During observation licensed practical r in R44's room to charter of the sing. R44 was positioned on his lefoam dressing from visible pressure ulchad no visible drain ulcer appeared to be (centimeters) by 1 any odor. LPN-C smeasure the ulcer "That's only schedus sprayed R44's wou cleanser; however, procedure and the LPN-C completed pressure ulcer. When interviewed LPN-C stated she has assigned or respondocument characted LPN-C stated floor pressure ulcer if diadministration reconstated R44's pression good," today compobserved it. R44's Treatment Adated 4/25/17, to 5 "Complete Weekly Health Management Evaluation] under for This was schedule basis on 4/26/17, 5/24/17 and 5/31/1	age 59 If on 6/2/17, at 9:57 a.m. Inurse (LPN)-C set up supplies hange his pressure ulcer in bed on an air mattress, eft side. LPN-C removed a nage present. R44's pressure of approximately 2 cm age present. R44's pressure of approximately 2 cm and in size. The wound lacked stated she did not routinely with dressing changes as, alled or whatever." LPN-C and using a saline wound a R44 became resistive to the dressing change was ceased. In omeasurements of R44's on 6/2/17, at 10:26 a.m. was unaware who was asible to measure and eristics of pressure ulcers. It is staff only measure the rected to by the treatment ord (TAR). Further, LPN-C ure ulcer, "Looked pretty ared to when she last dministration Record (TAR) ared to when she last dministration Record (TAR) wound evaluation [Monarch and (MHM) Weekly Wound forms tab for coccyx wound." at the completed on a weekly 6/3/17, 5/10/17, 5/17/17, 7. However, on 5/3/17, the das. "Absent from home." and	F 314				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
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F 314	on 5/10/17, the entirefused." Further, or recorded as, "Othe R44's MHM Weekly 4/30/17, identified Fulcer on his coccyx 2 cm (centimeters; 0.3 cm (depth) in sitissue (red tissue in wound bed. The ulpresent. Further, the section labeled, "Suchanges. Continues weeks." R44's MHM Weekly 5/1/17, (one day affidentified R44 had a his coccyx. The ulcollegible (length) X 0.2 cm (with 100% granulation of healing) in the widentified to have, "with no odor present again included a sewith, "NA [not applied clinic 5/3/17."	age 60 ry was recorded as, "Drug on 5/17/17, the entry was r / See Nurses Notes." y Wound Evaluation dated R44 had a stage III pressure as length) X (by) 0.1 cm (width) X ize with 100% granulation adicative of healing) in the leer had no drainage or odor he evaluation included a summary," with, "No new as to go to wound clinic every 2 y Wound Evaluation dated the previous evaluation), a stage III pressure ulcer on cer was measured as 2 cm width) X 0.3 cm (depth) in size tion tissue (red tissue indicative ound bed. The ulcer was Scant" drainage now present hat. Further, the evaluation action labeled, "Summary," cable] - Does go to wound		14		
	Evaluation dated 5/evaluation), identification with the visualize the wound the ulcer was mean cm (width) X 0.4 cm description of the would with no amount of contractions.	/19/17, (18 days after last ed R44 now had an, wn wound but unable to d bed]" ulcer on his coccyx. Issured as 2.3 cm (length) X 0.3 m (depth) in size. A, "Further wound," section was left blank or type of drainage being no dictation of any odor				

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F 314	being selected. Th "Wound Edges," wh "Intact." Further, th section labeled, "Su was left blank. R44's most recent I Evaluation dated 5/ evaluation), identific pressure ulcer on h measured as 1.8 cr 0.4 cm (depth) in si and 25% slough (de yellow in color) in tr identified to have no Further, the section identified, "No chan Wound has had soon R44's medical reco no additional docum demonstrate R44's characteristics had on a routine basis to monitoring for heali treatment/interventi R44's Ridgeview M Hyperbaric Healing had been seen for the pressure ulcer on 4 However, none of the center identified an characteristics of the visit on 5/17/17, onl to be, "SI [slightly] to dressing change or	e only selected option was, nich were identified as, he evaluation again included a summary," however, this section MHM Weekly Wound 30/17, (10 days after previous ed R44 had a stage III his coccyx. The ulcer was in (length) X 0.3 cm (width) X is with 50% granulation tissue ead tissue typically white or ne wound bed. The ulcer was in labeled, "Summary," higes to care plan at this time, improvement." In dwas reviewed. There was intentation identified to pressure ulcer and associated been consistently monitored to ensure appropriate ing and need for on changes. MHM Weekly Wound and III would be a streament and evaluation tissue edical Center Wound & Center sheets identified he areatment and evaluation of his intention identified the provided notes from the y measurements or the wound. The most recent y identified the pressure ulcer ess deep," and provided	F 3	14		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 314	were responsible to R44's pressure ulcom MHM Weekly Wou electronic medical R44's medical recoulcer had not been have been, "for corthe wound is healing [was] still effective." A facility Weekly CI Documentation polipurpose which included components should [underlined] charting components included ulcer, dimensions of and/or tunneling is 483.25(d)(1)(2)(n)(HAZARDS/SUPER) (d) Accidents. The facility must enfrom accident haza (2) Each resident reand assistance devenus ensure correct must ensure correct must ensure correct must ensure correct endicate in the state of the s	(DON) stated the floor nurses of measure and document for on a weekly basis using the end Evaluation form(s) in the record. The DON reviewed rd and stated his pressure tracked weekly, but should attinued monitoring to ensure g," and R44's, "Treatment of the december of the pressure did be a part of your weekly g," and listed several ing the stage of the pressure of the ulcer, and if undermining present. 1)-(3) FREE OF ACCIDENT VISION/DEVICES Insure that - Vironment remains as free rds as is possible; and eccives adequate supervision rices to prevent accidents. The facility must attempt to use tives prior to installing a side or a side rail is used, the facility et installation, use, and derails, including but not limited	F 3			7/12/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	B. WING _		06/0	2/2017
	PROVIDER OR SUPPLIER	.c	STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		1 00/02/2011	
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F 323	(1) Assess the resigner from bed rails prior (2) Review the risks the resident or resigner for the resident or resigner for the resident consent prior (3) Ensure that the appropriate for the This REQUIREMED by: Based on observative review, the facility finterventions and continuous identify the root caus implementing approximate the resident of 2 residents (R2 practice resulted in addition, the facility Wanderguard (persultational for 1 of 1 wandering and ensure worn as assessed freviewed for smoking include: FALLS: R24's annual Minimal 4/19/17, indicated Firmpairment. The Mextensive assistance and ambulation. The diagnoses of hyperical for the residence in	dent for risk of entrapment to installation. Is and benefits of bed rails with dent representative and obtain prior to installation. It bed's dimensions are resident's size and weight. The sident as evidenced to follow existing fall comprehensively assess falls to use of the fall to assist in priate, timely interventions for 24) reviewed for falls. This actual harm to R24. In a failed to ensure a sonal tracking alarm) was residents (R75) reviewed for ture smoking aprons were for 2 of 2 residents (R75, R27) mg. In the sidentified R24 needed are for bed mobility, transfers are MDS also identified tension, arthritis, dementia DS indicated R24 had two or nijury since the last	F 32	a. R 24 care plan was reviewed a updated appropriately for falls. R plan reviewed to reflect proper Wanderguard use and smoking saf 27 care plan was reviewed and updappropriately for smoking safety. b. Residents who have had a new since survey exit will be reviewed thoroughly for comprehensively ass for root cause of the fall, immediate interventions placed at the time of a and care plans updated with immediate interventions to prevent recurrent fainjury. All residents that utilize a Wanderguard will be reviewed to en Wanderguard will be reviewed to en Wanderguard sare placed and functioning for resident safety. All residents that smoke will be review ensure proper safety measures are implemented to prevent injury. Car plans updated as indicated. c. Policy and procedure for Falls Clinical Protocol, Code Alert Wander Monitor System, and Resident Smoreviewed and remain current. Eduto nursing staff on appropriate police.	fety. R dated / fall sessing a fall, diate alls and nsure ed to e ering oking acation	

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		245336	B. WING			06/0	02/2017
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F 323	R24's fall Care Are 4/28/17, identified being unsteady and moving from seate turning around and while walking, move surface to surface indicated R24 had and was also takin CAA identified R24 fall related injuries avoid complication R24's Fall Risk Evaindicated R24 had months and indicated R24 had months and indicated for falls. R24's care plan result had a potential for included the use of 6/14, which resulted hemorrhage, result mobility/cognition, higher risk for falls had fallen several interventions included and chair, ensanticipate needs, plight within reach wenvironment free coweekly, and monitor R24's undated Grotindicated safety intipled, floor mat and	a Assessment (CAA) dated R24 was at risk for falls due to d not able to stabilize himself d to standing position, walking, I facing the opposite direction ing on and off the toilet, and transfer. The CAA also falls since the last assessment g antianxiety medication. The was at risk for further falls and A care plan was developed to s and minimize risks. Caluation dated 4/18/17, multiple falls over the last 6 ted R24 was a moderate risk wised on 3/8/17, identified R24 falls/ accidents. Risk factors f medications, pain, a fall in d in an intracranial ting in impaired impulsivity, and placing him at the care plan identified R24 more times since the initial fall. Ded: bed in low position, fall de, mobility monitors on R24's ture they are on and working, provide rest periods, keep call when in room, keep of clutter, monitor vital signs or for medication side effects. Sup D nursing assistant sheet erventions for R24 were low	F 3	323	and ensuring proper procedures ar interventions are utilized per care of guides to prevent injury. Falls train with all licensed nurses on comprehensively assessing for the cause of the fall, immediate interver placed at the time of a fall, and care updated with immediate intervention prevent recurrent falls and injury. d. Director of Nursing or designed complete an audit of a random sele of resident is that fell for comprehe assessing for root cause of the fall, immediate interventions placed at the fall, and care plans updated with immediate interventions to prevent recurrent falls and injury. Social Second designee will complete an audit of a resident in that utilize a Wanderguar ensuring care plan is being followed prevent injury. Social Services or designee will complete an audit of a resident is that smoke to ensure planterventions are in place and care being followed to prevent injury. A will occur weekly times 4, monthly than audit results will be reported to committee for further review and recommendations.	root ntions e plans ns to e ection ensively he time th ervices of 3 d for d to ell roper plan is udits cimes 2	

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F 323	indicated R24's ala South Hall by the s left side with a skin and a pink area to Minnesota Incident a.m. identified a poanxiety as the reside constantly. No interest on the form. The F. 3/3/17, at 3:20 a.m. at 2:45 a.m., hower toileted, positioned on the form. The F. signed 3/6/17, indicated, positioned on the form was blank. Alt folding the scale where form was blank. Alt folding the scale was address R24's anx related to R24's anx related to R24's anx related to R24's and was found lying on between his night are received an injury celbow skin tear me 0.5 cm. The right scm x 0.5 cm. The rindicated R24 had predisposing physicand ambulating/traimproper/no footwowere identified. Im aid to the skin tears continued restless wheelchair. The Indated 5/5/17, identified	rm was going off down the cale. R24 was found on his tear to the top of the left hand the left forehead. The Report dated 3/3/17, at 3:00 ssible cause of the fall was lent was propelling himself eventions for R24 were listed all Scene Investigation dated all Scene Investigation dated identified R24 was last seen wer, the areas for last time, and offered fluids was blank cost Fall Investigation/ Plan cated R24 was last toileted at intervention added for staff to a not in use. The rest of the chough an intervention of as implemented, it did not liety or initiate an intervention	F 32	3		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 323	night stand away frinterventions were injury, it did not add intervention to minifall. R24's progress not indicated R24's beat 1:20 a.m. Staff is stomach "on the flof from a head lacera paramedics at 1:55 investigation. The Idated 5/15/17, identicated 5/15/17, identicated sat resident unable to state why Intervention added rounds. R24's 5/11 discharge report insutures to a head lawas similar to the florogress note did in his fall mat or if the time of the fall. The completed to determinimize potential. During observation was seated in his words and the ankle. During observation was lying in bed with bedside. A pair were on the floor.	e bed table, and move the om the bed. Although added to reduce the chance of dress a potential cause or an mize the risk of a subsequent of a	F 32	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	During interview on assistant (NA)-H state floor as directed and could not locate shoes R24 wore we NA-H also stated the his wheelchair with often fell off. NA-H help another reside R24's bedside. During interview on medication aid (TM be on the floor next the fall mat was not TMA-A found the faplaced it on the floor observed R24's sar worn. TMA-A furthe [Crocs sandals], due to wear." During interview on practical nurse (LPI initiated right away source" of the fall. falls committee to hereiwed at stand of the fall. Friday. LPN-A state socks on or the yell observed the Crocs no tread on the bott need to take those out." LPN-A then re R24's room.	ge 67 5/31/17, at 7:56 p.m. nursing ated the fall mat was not on d. NA-H looked for the fall mat et. NA-H stated the only ere the yellow Crocs sandals. At when R24 was propelling his feet his Crocs sandals then left the room and went to nt. No floor mat was put by 5/31/17, at 8:06 p.m. trained A)-A stated a fall mat was to to R24's bed. TMA-A stated at the bedside on the floor. Ill mat behind R24's door and or near R24's bed. TMA-A ndals and stated they were er stated, "I don't like them mbest thing for an elderly man 6/1/17, at 1:12 p.m. licensed N)-A stated an intervention is following a fall "if we know the LPN-A stated there was not a ter knowledge, but falls were to meetings Monday through ed R24 usually had gripper ow Crocs sandals. LPN-A is sandals and stated there was tom of the sandals, "I think we away, I'm going to take those emoved the sandals from	F3	23			

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(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
unfolded and not in During interview or stated intervention into place following there were too martheir heads and not LPN-C stated she supervisors, but the stated there were stated the facility docause of a fall or in interventions to properly a can walk with she over hears the one offered to take falls, "definitely need to be unfolded and was propelling himself in gripper socks up a During interview or registered nurse (First stated on 5/3/17, a identified following into place did not put the fall on 5/11/17, 5/3/17, and was not had been initiated. Comprehensive fall completed with the further stated that	n use. n 6/2/17, at 8:10 a.m. LPN-C is are not routinely being put go a fall. LPN-C further stated in people falling and hitting one is doing anything about it. communicated this to the ey just "blow it off." LPN-C is on many new nurses here that they are doing. LPN-C further lid not try to determine the implement appropriate event future falls. LPN-C stated assistance and many times extaff say just sit down, and note him for a walk. LPN-C stated and to be taken more seriously." In on 6/2/17, at 8:31 a.m. the is the South Hall was again not in use. R24 was self in his wheelchair wearing and down the South Hall. In 6/2/17, at 9:26 a.m. RN)-A reviewed R24's falls and a causative factor was not the fall and the intervention put orevent future falls. RN-A stated was similar to the fall on of sure if a bladder assessment RN-A further stated a l assessment was only an interdisciplinary team (IDT)		3		
	PROVIDER OR SUPPLIER TATES AT DELANO L SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From particles of the supervisor of the supervisors of the supervisors of the supervisors of the stated there were supervisors of a fall or in the stated the facility of the supervisor of	PROVIDER OR SUPPLIER TATES AT DELANO LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 unfolded and not in use. During interview on 6/2/17, at 8:10 a.m. LPN-C stated interventions are not routinely being put into place following a fall. LPN-C further stated there were too many people falling and hitting their heads and no one is doing anything about it. LPN-C stated she communicated this to the supervisors, but they just "blow it off." LPN-C stated there were so many new nurses here that don't know what they are doing. LPN-C further stated the facility did not try to determine the cause of a fall or implement appropriate interventions to prevent future falls. LPN-C stated R24 can walk with assistance and many times she over hears the staff say just sit down, and no one offered to take him for a walk. LPN-C stated falls, "definitely need to be taken more seriously." During observation on 6/2/17, at 8:31 a.m. the scale at the end of the South Hall was again unfolded and was not in use. R24 was self propelling himself in his wheelchair wearing gripper socks up and down the South Hall. During interview on 6/2/17, at 9:26 a.m. registered nurse (RN)-A reviewed R24's falls and stated on 5/3/17, a causative factor was not	PROVIDER OR SUPPLIER TATES AT DELANO LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 unfolded and not in use. 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During interview on 6/2/17, at 9:26 a.m. registered nurse (RN)-A reviewed R24's falls and stated on 5/3/17, a causative factor was not identified following the fall and the intervention put into place did not prevent future falls. RN-A stated the fall on 5/11/17, was similar to the fall on 5/3/17, and was not sure if a bladder assessment had been initiated. RN-A further stated a comprehensive fall assessment was only completed with the MDS assessments. RN-A further stated that an interdisciplinary team (IDT) was supposed to meet every morning for stand	PROVIDER OR SUPPLIER 245336 PROVIDER OR SUPPLIER ATES AT DELANO LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 unfolded and not in use. During interview on 6/2/17, at 8:10 a.m. LPN-C stated interventions are not routinely being put linto place following a fall. 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RN-A stated the fall on 5/11/17, was similar to the fall on 5/3/17, and was not sure if a bladder assessment had been initiated. RN-A further stated a comprehensive fall assessment was only completed with the MDS assessments. RN-A further stated that an interdisciplinary team (IDT) was supposed to meet every morning for stand	PROVIDER OR SUPPLIER 245336 245336 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328 SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 unfolded and not in use. During interview on 6/2/17, at 8:10 a.m. LPN-C stated interventions are not routinely being put into place following a fall. LPN-C further stated there were too many people falling and hitting their heads and no one is doing anything about it. LPN-C stated she communicated this to the supervisors, but they just "blow it off." LPN-C stated there were so many new nurses here that don't know what they are doing. LPN-C further stated the facility did not try to determine the cause of a fall or implement appropriate interventions to prevent future falls. LPN-C stated results and the same over hears the staff say just sit down, and no one offered to take him for a walk. LPN-C stated falls, "definitely need to be taken more seriously." During observation on 6/2/17, at 8:31 a.m. the scale at the end of the South Hall. During interview on 6/2/17, at 9:26 a.m. registered nurse (RN)-A reviewed R24's falls and stated on 5/3/17, a causative factor was not identified following the fall and the intervention put into place did not prevent future falls. RN-A stated the fall on 5/11/17, was similar to the fall on 5/3/17, and was not sure if a bladder assessment had been initiated. RN-A further stated a comprehensive fall assessment was only completed with the MDS assessments. RN-A further stated that an interdisciplinary team (IDT) was supposed to meet every morning for stand

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F 323	time. During interview on stated the scale at a supposed to be foldalso stated it was let the time. During interview on director of nursing (had changed since companies a few managements of the progress notes form in risk managements of the progress notes form in risk managements of the progress notes form in risk managements of the progress of the stated she completed analysis following the stated she completed Analysis following the stated R24's fall on Wednesday and the incident until 5/5/17 potential cause was thought it could be a trazodone (antideproon stated after lof all investigation was fall on 5/11/17. Don sinterventions to be stated after lof the fall mat was on on 5/11/17. Don's interventions to be stated to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on the fall on 5/11/17, R24 to be toileted on the fall on the fall on 5/11/17, R24 to be toileted on the fall on the fall on 5/11/17, R24 to be toileted on the fall on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17, R24 to be toileted on the fall on 5/11/17.	6/2/17, at 9:37 a.m. NA-D the end of the South Hall was led up when not in use. NA-D off in the down position most of 6/2/17, at 10:33 a.m. the DON) stated the fall process switching management conths ago. When a resident pposed to document the fall in and fill out an investigation ement. The DON stated the	F 3	23			

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F 323	identify if toileting the fall. DON state evaluated for safe been removed on contacted. DON falls at the IDT me was not always locause of the fall to place. DON furth effectively evaluated complete investig was aware of incorplete investig was aware of incorplete investig was aware of incorplete docume immediately follow. A facility and she deassurance to fix the dath opportunic complete docume immediately follow. A facility policy Fadirected staff to, "staff will attempt the 24 hours of the fabe readily identified various relevant in assessment of the until falling reduce identified for its condividual continuous without waiting for WANDERGUARD R75's admission R75 had moderated wandering behaving getting to a potential policy.	times was a potential cause of ted R24's shoes had never been by and stated the shoes had 6/1/17, and family was further stated when reviewing teetings, the fall investigation oked at to try and determine the put effective interventions into ter stated falls can not be ted without looking at a lation. DON further stated she complete documentation and lack offlowing a fall for resident's at the eveloped a plan in quality the situation, however; had not try to train the nurses on the lentation and lack of interventions wing a fall. Ills-Clinical Protocol dated 5/13, For an individual who has fallen, to define possible causes within ll If underlying causes cannot be enaure or category of falling, as or stops or until a reason is continuation (for example, if the less to try and get up and walk or assistance)."	F3	323			

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F 323	at risk for elopement leaving the facility a were to have no incremain safe during Further, the care pleased was every leave of the core o	drinistration Records (TAR's) and related to attempts of and wandering. R75's goals cidence of elopement and placement at the facility. In indicated an intervention of, red." Review of the medical elopement attempts since diministration Records (TAR's) a 2/1/17,-5/31/17. The TAR's documentation to check do for placement or function the nursing order was written of wanderguard daily," and red every shift for placement. on 5/31/17, at 1:33 p.m. R75 smoking patio having a not have a Wanderguard on. 5/31/17, at 7:17 p.m. R75 was op of the blankets, fully atching television. R75 did not red on. The Wanderguard was side table, however; the band	F 32	3			

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F 323	When interviewed TMA-A stated R75 would sound an also outside. At 7:30 p. to R75's room toge was sitting on his bear was R75's Wanderguard was R75's Wanderguard stated R75 should and not sitting on the During interview or DON stated she we wanderguard. Toge DON looked at R75 broken on his bear wanderguard on Fatated it was on the placement of R75's When interviewed stated R75 was an Wanderguard local stated she was not placement or check wanderguard was not know how to check working, adding, "Touring interview or stated R75 did not stated staff do not wears a Wanderguard was not know how to check working, adding, "Touring interviewed stated R75 did not stated staff do not wears a Wanderguaware of which reserviewed stated R75 wore a	wore a Wanderguard and it arm if he attempted to go and surveyor and TMA-A went either and R75's Wanderguard bedside table. The band on the broken. TMA-A looked at and it attached to his body he bedside table and I have it attached to his body he bedside table. In 5/31/17, at 7:33 p.m. the ould go and look at R75's gether, the surveyor and the 5's Wanderguard that was side table. The DON took the laced the band and placed the R75's right wrist. The DON to TAR for staff to check is Wanderguard every shift. In 6/1/17, at 7:54 a.m. NA-K elopement risk and wore a ted on his wheelchair. She taware if any staff checked the ked to see if R75's working. NA-K stated she did neck if a Wanderguard was That is a good question." In 6/1/17, at 8:04 a.m. NA-J wear a Wanderguard. NA-J check to see if a resident lard, adding staff was just	F 32	3			

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F 323	was on and the nuresident's medicati LPN-A stated the refunction of the War order for checking got entered on 5/3 one was checking R75's Wanderguard was stated she was not was located on his A facility Code Aler policy dated 8/2013 each transmitter in nurse of each residunit. The alarm and by taking the residunit. The alarm and by taking the residunit or ankle band weekly basis for we necessary. This we resident's medical subject to the weekly basis for we necessary. This we resident's medical subject to the weekly basis for we necessary. This we resident's medical subject to the weekly basis for we necessary. This we resident's medical subject to the weekly basis for we necessary. This we resident's medical subject to the weekly basis for we necessary. This we resident's medical subject to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary. This we resident to the weekly basis for we necessary.	rses documented in the on administration record. iight shift staff checked the nderguard. LPN-A stated the R75's Wanderguard had just 1/17, and prior to 5/31/17, no the placement or function of id. When informed the on his right wrist, LPN-A aware of that and thought it ankle. It Wandering Monitor System 3, indicated on a weekly basis use would be tested by the dent who wore the transmitter id transmitter would be tested ent through the alarmed doors ropriately in the resident's me policy also indicated the would be checked on a gear and tear, and replaced as ould be documented in the record. IDS dated 2/21/17, identified cognitive impairment, required with activities of daily living use any tobacco products. In gnosis Report identified R75 admission to the facility of,	F 32	3		
	facility," and listed	currently smokes at this a goal for R75 of, "Resident The care plan listed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		245336	B. WING _		06	/02/2017		
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F 323	-	_	F 32	3				
		included, "Independent with ation" and "Smoking apron per						
	indicated R75 had deficit and smoked evaluation identified equipment which in The smoking evaluinterventions indica himself outside, ligh properly dispose of accepting of wearing accepting of facility policy and times we	aluation dated 3/10/17, cognitive loss and a visual two to five times per day. The d R75 required adaptive acluded a "Smoking apron." ation summary and ated R75 was able to safely get at his own cigarette, and his cigarette. R75 was ag a smoking apron and a smoking times. The smoking ere also reviewed with R75 and and they agreed to them.						
	stated he went outs and there were spe by the nurse's stati smoke. He also sta	side four times a day to smoke ecific times of the day posted on of when he could go out to ated the staff gave him his was time to go out to smoke.						
	went outside to the wheelchair. He had but the smoking ap apron remained fol he was outside sminis cigarette by him extinguish his cigar However, the entire safety apron remain was no staff supervision.	on 5/30/17, at 1:32 p.m. R75 smoking patio in his d a smoking apron on his lap, where the smoking apron on his lap, where the smoking apron was not opened. The ded on his lap the entire time oking. R75 was able to light inself, ash safely, and rette without difficulty. It is the entire time R75 was smoking, the ned folded on his lap. There wising R75 while he smoked. 5/31/17, at 1:28 p.m. R75 was its station requesting his						

		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G		COMPLETED	
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F 323	cigarettes. Staff halighter, and a smoch himself outside to the smoking apron rendered 1:31 p.m. NA-L we and told R75 he moutside smoking. It apron on R75 and facility. On 5/31/17, at 1:33 he wore the smokind did not, depending typically just placed On 5/31/17, at 7:23 smoker and he we further stated R75 when he was smok R75 needed a staff R75 when he smol During interview or stated R75 was a sresidents that smo smoking and if the and extinguish safe smoke. TMA-A als residents had to work when interviewed DON stated R75 wasked to wear a smoutside to smoke. Usually just set the when he smoked. assessment indical	anded him two cigarettes, his king apron. R75 propelled the smoking patio. The nained folded on his lap. At nt outside to the smoking patio ust have his apron on to be NA-L placed the smoking then went back inside the Sp.m. R75 stated sometimes ng apron and sometimes he on how he felt. R75 stated he dethe smoking apron on his lap. Sp.m. NA-H stated R75 was a nt outside to smoke. She had to wear a smoking apron king and she did not believe femember to be outside with		3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 323	During interview or practical nurse (LP an apron when he evaluation. LPN-A the smoking apron chest and body and LPN-A also added lap. "This could port of the smoking apron chest and body and LPN-A also added lap. "This could port of the smoking apron interfere with a listed a question, "(In lighter/matches?" by the evaluator. Find the evaluator	n 6/1/17, at 8:35 a.m. licensed N)-A stated R75 had to wear smoked per his smoking stated R75 should be wearing over his neck so it covered his d not just be folded on his lap. R75 often just placed it on his otentially be a problem." IDS dated 4/3/17, identified cognitive impairment and	F 32	3			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ¹ A. BUILDI	TIPLE CONSTRUCTION ING			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 323	three single cigarett nurse (LPN)-E. R27 walker and sat in a placed the folded up outside and proceed and smoke them. From and had no burn ho stated the staff was the provided smoking questioned it." During interview on stated R27 went our during her shift at the NA-D stated R27 to with him and staff of wanted it as, "That's of the smoking approximate to monitor R27 when the wanted it as, "That's of the smoking approximate to monitor R27 when the wanted it as, "That's of the smoking approximate to monitor R27 when the wanted it as, "That's of the smoking approximate to monitor R27 when the wanted it as, "That's of the smoking approximate to monitor R27 when the wanted it as, "That's of the smoking approximate to monitor R27 when the wanted the wanted for need flame retardant approximate the wanted for need flame retardant approximately would los privileges, until research to smoke in the wanted for sate of the wanted for sate of the wanted for need flame retardant approximately would los privileges, until research to smoke in the wanted for sate of the wanted for	tes from licensed practical ambulated outside using his chair on the patio. R27 promoking apron on the table ded to light his cigarette(s) R27 did not drop any ashes also visible in his clothing. R27 aware he was not wearing apron but had, "never as a designated, "smoke times." sook the smoking apron outside nly assisted him with it if he is up to him." NA-D stated use on was, "Highly bugh to reduce the risk of a she had never been directed on he is outside smoking. The following apron as directed by alluation. The formation of the following would be of adaptive equipment (i.e., on, cigarette extension and the following would be independent smoking valuated and determined to adependently.	F 3				7/40/47
F 329 SS=D	483.45(d)(e)(1)-(2) FROM UNNECESS	DRUG REGIMEN IS FREE SARY DRUGS	F 3	29			7/12/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		E SURVEY IPLETED
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F 329	Each resident's dru unnecessary drugs drug when used (1) In excessive do therapy); or (2) For excessive d (3) Without adequal (4) Without adequal (5) In the presence which indicate the odiscontinued; or (6) Any combination	sary Drugs-General. Ig regimen must be free from An unnecessary drug is any se (including duplicate drug uration; or	F 32	,		
	resident, the facility (1) Residents who leadings are not given medication is necessional to a diagnostic clinical record; (2) Residents who leading additional record is reduced in the facility of the fac	chensive assessment of a must ensure that have not used psychotropic these drugs unless the ssary to treat a specific esed and documented in the set of the second documented in the second documented documented in the second documented				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	с	4	STREET ADDRESS, CITY, STATE, ZIP CODE 133 COUNTY ROAD 30 DELANO, MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	This REQUIREMENT by: Based on interview facility failed to compustify the need for medication for 1 of unnecessary medicated R21's quarterly Min 4/14/17, indicated Fimpairment, and hat hypercholesterolem hypertension, Parkitarthropathy (diseas R21's Order Summindicated R21 had a Simvastatin, (choles milligrams (mg) by other and unspecificated at end 2/8/14 Summary Report diffollowing labs, "Chofunction tests) q (evidate of 2/8/14. R21's Chemistry re R21's cholesterol let (milligrams per decimication medication of 1 of	and document review, the aprehensively assess and a cholesterol-lowering 5 residents (R21) reviewed for eations. imum Data Set (MDS) dated R21 had severe cognitive d diagnoses including hia (high cholesterol), nson's disease, and e of a joint). ary Report dated 5/17/17, current physician orders for, sterol reducing medication) 20 mouth at bedtime related to ed hyperlipidemia with an b. Further, the Order rected staff to draw the olesterol panel and LFT's (liver very) 9 months" with an order	F 329	a. R 21 had cholesterol level chec 6/5/2017. b. All residents will be reviewed at care conference to ensure proper lamonitoring is reviewed to ensure redoes not receive unnecessary medications. c. Education provided to nursing ensure monitoring of lab orders and completion as ordered by provider. Clinical pharmacist will be educated monitoring unnecessary labs order or unnecessary medications for resid. Director of Nursing will complete monthly Audit of 3 resident clinical pharmacist reviews to ensure the monitoring unnecessary labs order or unnecessary medications for residudit results will be reported to QA committee for further review and recommendations.	t next ab esident staff to d d on ed and sidents. te a ed and sidents.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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F 329	During interview or director of nursing physician's order wilpid and liver funct months. The DON determine if these ordered. The DON to find any docume record to show the ordered. When interviewed consulting pharmar "probably going to and liver function to the reason R21's of tests were drawn will Risperdal (an antimedication was disstated since the distance of R21's aggressive with tre CP stated the plan R21's cholesterol leaded "It doesn't reif effective or not, be change R21's there effects of Simvasta muscle weakness, begin to suspect R cause of R21's mu During a subseque p.m. the DON state function tests should restrict the state of the plan R21's mu	n 6/2/17, at 2:20 p.m. the (DON) stated R21 had a written on 2/10/14, to have a ion test drawn every nine stated she was unable to labs had been drawn as further stated she was unable entation in R21's medical se labs had been drawn as on 6/2/17, at 2:39 p.m., cist (CP) stated he was, ask" to have R21's cholesterol ests discontinued. CP stated holesterol and liver function was because R21 was on psychotic medication), but that is continued on 12/16. CP also secontinuance of R21's no reason to keep such a close esterol level. CP stated age, he was a lot less ating R21's cholesterol levels. was to continue to address evel with Simvastatin, and, eally matter" if the Simvastatin because there was no plan to apy. CP added potential side atin included muscle pain and but stated he would not even 21's use of Simvastatin was a scle weakness. ent interview on 6/2/17, at 3:23 and R21's cholesterol and liver lid have been drawn as accility should have identified the	F 32	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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F 329		ge 81 on 6/5/17, at 1:38 p.m. the D) stated it was, "not at all	F 32	9		
	important" to check tests because it rea difference. The MD "should be followed questioned residen	cholesterol and liver function ally does not make a also stated physician orders, I." The MD stated she really ts' need to be on statins (class wer cholesterol levels) while in				
	6/15, indicated to o of medication thera potential adverse cattending physician pharmacist perform appropriate, effective Further, the policy is regimen was evaluate whether prolonged medication was income of medication to the policy is regimen was evaluated to the policy in the policy is regimen was evaluated to the policy in the policy is regimen was evaluated to the policy in the policy in the policy is regimen was evaluated to the policy in the policy in the policy is regimen was evaluated to the policy in the policy in the policy is regimen was evaluated to the policy in the policy in the policy is regimen was evaluated to the policy in the policy in the policy in the policy is regimen was evaluated to the policy in the policy in the policy in the policy in the policy is regimen was evaluated to the policy in the policy i	ARMACEUTICAL SVC -	F 42	25		7/12/17
	pharmaceutical ser that assure the acc dispensing, and ad	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.				
		ation. The facility must e services of a licensed				
	provision of pharma	tation on all aspects of the acy services in the facility; NT is not met as evidenced				

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F 425	by: Based on observareview, the facility orders were reconsadministration error observed to receiv survey. Findings include: R26's quarterly Mindel Algorithms include: R26's physician facts and complaints of, requested her Lass 40 mg being given administered). The "Yes," adding, "But weights and plans. During observation on 5/31/17, at 6:18 (LPN)-B prepared cart in the hallway, the surveyor of the administered which tablet. The packaga utomated machinal administration instruction in the R26's Medication Algorithms in the Mindel Algori	ation, interview and document failed to ensure medication ciled accurately to prevent fors for 1 of 7 residents (R26) is emedications during the medications during the medications during the ser, the MDS identified R26 had for the liver and consumed a fused to reduce fluid in the sex signed 4/27/17, identified R26 "Water retention," and fix (a diuretic) be increased to twice a day (a total of 80 mg is physician responded with, a only if she consents to daily to see me within 2 weeks." In of medication administration is p.m. licensed practical nurse R26's medications at a mobile LPN-B provided a package to	F 425	a. R 26 orders were reviewed faccuracy and to ensure all order processed to prevent medication b. All resident orders will be revensure all orders are processed prevent medication errors. c. Education provided to all lice nurses on medication reconciliat timely processing of orders. Nuwill review all orders daily for proprocessing. d. Director of Nursing or design complete an audit of 3 residents orders to ensure proper medicat reconciliation and timely process prevent medication errors. Audi occur weekly times 4, monthly timed audit results will be reported committee for further review and recommendations.	s were n errors viewed to to ensed ion and irsing staff oper nee will with new ion sing to ts will mes 2 I to QAPI		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 425	mg tablet of Lasix in R26's medical recomedication orders. dated 5/9/17, ident her physician and i "Your Updated Medical orders incling tablet," with direction the front by nurs 5/11/17. An additional subsidated 5/17/17, ident the emergency rooe Encounter," and, "Sometic including, "Furoser directed, "Take 3 tamorning," for alcohascites (fluid build R26's nursing progidentified R26 returned to the recome directed, "Take 3 tamorning," for alcohascites (fluid build R26's nursing progidentified R26 returned R26's nursing progidentified R26 returned R26's harbeen clarified. When interviewed assistant director or reviewed R26's harbeen getting Lasix 80 mg a day) since		F 4:	25			

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	department since the visit was Lasix 20 m 60 mg a day). ADO and spoke with R26 mg a day being adri 60 mg a day being The ADON stated relooked," at the paper to ensure R26 was Lasix. The ADON at been missed by, "s who should have refurther, ADON stated clarified could cause. A facility medication requested, but none 483.45(c)(1)(3)-(5) REPORT IRREGULTION TO BETT IR	linic and emergency nen. The order listed at each ng three times a day (a total of DN stated she called the clinic D's physician who stated the 80 ministered was correct, not the identified on the visit note(s). nursing home staff, "should of er work and clarified the orders receiving the correct dose of idded the discrepancy had everal" different staff members eviewed the paperwork. ited the discrepancy not being e a medication error for R26. In reconciliation policy was e was provided. DRUG REGIMEN REVIEW, LAR, ACT ON Review en of each resident must be nce a month by a licensed drug is any drug that affects ociated with mental processes se drugs include, but are not the following categories:	F 4			7/12/17	

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F 428	to the attending p facility's medical and these reports (i) Irregularities in drug that meets the direction of this section of this section of the thing this review separate, written attending physicial director and director and director and the irregularity has be action has been the physician should the resident's medical irregularity has be action has been the physician should the resident's medical tregularity has be action has been the physician should the resident's medical tregularity has be action has been the physician should the resident's medical tregularity has be action has been the physician should the resident's medical tregularity has been the physician should frames for the difference of the pharmal identifies an irregularity facility failed to erreviews had recover the residential to entire the pharmal identifies an interview of the pharmal identifies an irregularity failed to erreviews had recover the residential to entire the pharmal identifies an irregularity failed to erreviews had recover the residential to entire the pharmal identifies an irregularity failed to erreviews had recover the residential to entire the pharmal identifies an irregularity failed to erreviews had recover the residential to entire the pharmal identifies an irregularity failed to erreview had recover the residential to entire the pharmal interview of the pharmal identifies an irregularity failed to entire the pharmal interview of the pharmal interview	hysician and the director and director of nursing, a must be acted upon. clude, but are not limited to, any he criteria set forth in paragraph for an unnecessary drug. es noted by the pharmacist must be documented on a report that is sent to the an and the facility's medical tor of nursing and lists, at a ident's name, the relevant drug, by the pharmacist identified. physician must document in the all record that the identified een reviewed and what, if any, aken to address it. If there is to the medication, the attending document his or her rationale in dical record. Just develop and maintain policies or the monthly drug regimen e, but are not limited to, time ferent steps in the process and cist must take when he or she ularity that requires urgent action	F4	F 428 a. R 21 had cholesterol le 6/5/2017. b. All residents will be rev		

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(X4) ID PREFIX TAG			SHOULD BE	(X5) COMPLETION DATE			
F 428	cholesterol-lowering Findings include: R21's quarterly Min 4/14/17, indicated Fimpairment, and ha hypercholesterolem hypertension, Parki arthropathy (diseas R21's Order Summ indicated R21 had Simvastatin,(choles milligrams (mg) by other and unspecifi order date of 2/8/14 Summary Report d following labs, "Cho function tests) q (ex date of 2/8/14. R21's Chemistry re R21's cholesterol le (milligrams per dec mg/dL, high density mg/dL, low density bilirubin 0.8 mg/dL, were within the nor medical record lack level and liver funct as ordered since 8/ R21's monthly Pha 8/1/16 to 5/23/17, la R21's lack of labora ongoing use of sim	simum Data Set (MDS) dated R21 had severe cognitive and diagnoses including hia (high cholesterol), inson's disease, and se of a joint). Tary Report dated 5/17/17, current physician orders for, sterol reducing medication) 20 mouth at bedtime related to ed hyperlipidemia with an 4. Further, the Order irected staff to draw the olesterol panel and LFT's (liver very) 9 months" with an order very) 9 months with an order very was 132 mg/dL, illiter), triglyceride level 73 / lipoprotein cholesterol 47 cholesterol 70 mg/dL, total direct bilirubin 0.2 mg/dL, all mal range. However, R21's ked evidence her cholesterol tion tests had been re-checked (21/15 (a period of 22 months).	F 428	per orders c. Education provided to nu ensure monitoring of lab orde completion as ordered. d. Director of Nursing or de complete an audit of 3 reside completion of lab monitoring Audits will occur weekly time times 2 and audit results will to QAPI committee for furthe recommendations.	ers and signee to ents to ensure as ordered. s 4, monthly be reported		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245336	B. WING		06	/02/2017	
	PROVIDER OR SUPPLIER	_C		STREET ADDRESS, CITY, STATE, ZIP CO 433 COUNTY ROAD 30 DELANO, MN 55328		-	
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F 428	director of nursing physician's order w lipid and liver function months. The DON determine if these lordered. The DON to find any docume record to show the ordered. When interviewed consulting pharmac "probably going to and liver function to the reason R21's consulting pharmac "probably going to and liver function to the reason R21's consulting pharmac "probably going to and liver function was disstated since the dis Risperdal (an anti-pmedication was disstated since the dis Risperdal, he sawn eye on R21's chole because of R21's aggressive with tre CP stated the plan R21's cholesterol leadded "It doesn't reif effective or not, because of R21's there effects of Simvastamuscle weakness, begin to suspect Ricause of R21's must buring a subseque p.m. the DON state function tests should be consulted to the plan R21's must be plan to suspect Ricause of R21's must be plan to suspect R	(DON) stated R21 had a pritten on 2/10/14, to have a sion test drawn every nine stated she was unable to labs had been drawn as further stated she was unable entation in R21's medical see labs had been drawn as so on 6/2/17, at 2:39 p.m., cist (CP) stated he was, ask" to have R21's cholesterol ests discontinued. CP stated holesterol and liver function was because R21 was on expectation and liver function was because R21 was on expectation of R21's no reason to keep such a close esterol level. CP stated age, he was a lot less ating R21's cholesterol levels. was to continue to address evel with Simvastatin, and, eally matter" if the Simvastatin ecause there was no plan to apy. CP added potential side atin included muscle pain and but stated he would not even 21's use of Simvastatin was a scle weakness. Int interview on 6/2/17, at 3:23 and R21's cholesterol and liver lid have been drawn as a cility should have identified the	F 4	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245336	245336 B. WING			/02/2017
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F 428	When interviewed of medical director (Mimportant" to check tests because it readifference. The MD "should be followed questioned resident of drugs used to low the nursing home. A facility Consultant Provider Requiremedicated the consuresponsible for reviof each resident at the review and finding record or in a readility policy also identified was responsible prescriptotential or actual properties of the provident of the provid	D) stated it was, "not at all cholesterol and liver function ally does not make a also stated physician orders, I." The MD stated she really ts' need to be on statins (class wer cholesterol levels) while in the Pharmacist Services ents policy dated 6/15, altant pharmacist was ewing the medication regiment least monthly and document ings in the resident's medical ly retrievable format. The did the consultant pharmacist communication to the ber and the facility leadership problems detected and other medication therapy orders and monitoring of medication regulatory compliance issues the DRUG RECORDS, RUGS & BIOLOGICALS covide routine and emergency als to its residents, or obtain the ement described in part. The facility may permit and to administer drugs if State by under the general	F 42			7/12/17

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 431	pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee (b) Service Consult employ or obtain the pharmacist who (2) Establishes a sydisposition of all codetail to enable an (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordant professional principappropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance with facility must stolocked compartment controls, and permit have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Drug Control Act of 1976	vices (including procedures turate acquiring, receiving, ministering of all drugs and to the needs of each resident. The facility must eservices of a licensed vices of receipt and ntrolled drugs in sufficient accurate reconciliation; and the drug records are in order and all controlled drugs is riodically reconciled. The graph of the facility must be not be not with currently accepted oles, and include the ory and cautionary expiration date when the sand Biologicals. The graph of the facility must be not with currently accepted oles, and include the ory and cautionary expiration date when the sand Biologicals. The graph of the facility must be not with State and Federal laws, and biologicals in the sunder proper temperature it only authorized personnel to	F 43	.1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 431	quantity stored is medications in clude: UNSECURED MED A facility Controlled dated 6/15, identifications in clude: UNSECURED MED A facility Controlled dated 6/15, identifications in clude: UNSECURED MED A facility in according in controlled substance in controlled substance in controlled dated 6/15, identifications in clude: UNSECURED MED A facility Controlled dated 6/15, identifications in clude: UNSECURED MED A facility in according in controlled substance in controlled	bution systems in which the inimal and a missing dose can NT is not met as evidenced and the inimal and a missing dose can NT is not met as evidenced and it is not met as evidenced and it is not met as evidenced and it is not implement policies and it is after a safe storage of controlled and it is after a safe storage of controlled and it is after a safe storage of controlled and it is after a safe storage of controlled and it is after a safe storage of controlled and it is after a safe and it is af	F 43	a. Medication room will remain locall times except when in the preser licensed nurse. Shift to shift narcot counts will be completed at shift chb. Medication room will remain locall times except when in the preser licensed nurse. Shift to shift narcot counts will be completed at shift chc. Policy and procedure for the factoricled Substance policy was reand remains current. Education procedure for the factoricled Substance Storage policensuring medications on the facility Controlled Substance Storage policensuring medication room remaining locked at all times except in the presence of a licensed nurse, and signing of Shift to shift narcotic counts to be completed at the end of one shift at to the start of the next shift to preved diversion. d. Director of Nursing or designed complete an audit of medication room remains locked except in presence of a licensed nurse and to complete an audit of each shift to snarcotic count sheets to ensure the completed at the change of each shaudits will occur weekly times 4, m times 2 and audit results will be repto QAPI committee for further revier recommendations.	ice of a ic ange. cked at ice of a ice of a ice of a ice ange. cility eviewed rovided expenses and prior ent expenses the expenses to one to the expenses of t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 431	the refrigerator was unlocked gold color the hinge. The padd refrigerator without refrigerator content two opened bottles medication and clainside - one each fremaining medicat reviewed with the lator be correct. When interviewed observation, LPN-/have been kept loc [lorazepam] in ther was considered to should be double led. During interviewed consulting interviewed consulting pharma should have been facility policy, "It should be correct." When interviewed consulting pharma should have been facility policy, "It should be correct." LACK OF DOCUM On 5/30/17, at 9:20 cart was reviewed (LPN)-A. A separa affixed to the cart a several various nar stated narcotics we should be should be correct.	th the counter. On the side of is a hinge device and a red pad lock inserted through lock was removed from the it having to use a key and the its reviewed. Contents included its of lorazepam (an anti-anxiety loss IV controlled substance) for R39 and R5. The amount of ion inside the bottles was bound register count and found immediately following the A stated the refrigerator should exed, "because there's Ativan e." LPN-A stated lorazepam be a narcotic medication and	F 43	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 431	completed on a flow the medication cart to the surveyor whi Shift Controlled Su 5/17. The flowshed for nurses to record including the date, each shift nurse to and departure. A to required to satisfy the laid out on the flow were left blank and May 1 - One of six May 4 - One of six May 5 - Three of six May 12 - One of six May 12 - One of six May 13 - One of six May 14 - One of six May 15 - One of six May 16 - One of six May 17 - One of six May 17 - One of six May 18 - One of six May 19 - One of six Ma	wsheet in the binder housed on its. LPN-A provided the binder ch contained a Change Of bistance Count Sheet dated et contained several columns dinarcotic count information shift with additional spacing for sign as they count with arrival otal of six signatures were the counting requirements as sheet. However, several fields unsigned as follows: spaces was left blank; spaces was left blank; spaces was left blank; contained sp	F4	.31			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 433 COUNTY ROAD 30 DELANO, MN 55328			
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F 431	were reviewed and used, however, ag blank and unsigne May 1 - one of six May 5 - two of six shift, was left blank May 12 - two of six May 26 - two of six AM shift, was left to May 27 - one of six May 27 - one of six Arandom narcotic medications were subsequent past in tracking sheets we which again identif for each medication narcotic count was When interviewed director of nursing medications should change," and docus ubstance count sfelt the carts were they are not signing should be signing policy," in order to and, "decrease the During interview or consulting pharma completed some in past six months or shift narcotic count.	I identified the same flowsheet ain, several fields were left d as follows: spaces was left blank; spaces, being the entire AM K; spaces was left blank; spaces was left blank; spaces was left blank; spaces, again being the entire blank and; spaces was left blank. count was completed and all found to be correct with LPN-A. months of controlled substance are requested and reviewed ied several unsigned spaces in cart in which the shift to shift				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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	CP stated he notified who, "corrected the count should be do facility policy to ensipossible if diversion took what." During subsequent p.m. the DON state of any concerns with counts not being do months by the CP. A signed listing providentified 13 reside orders for narcotic of the facility Controlled dated 6/2015, identicontrolled substance the facility in according to the facility in ac	ed the DON of these concerns a staff." Further, CP stated the cumented according to the cure, "rapid detection," was a occurred to, "find out who interview on 6/2/17, at 2:38 and she was never made aware the medication cart narcotic ocumented in the past several wided by the DON on 6/2/17, at in the facility had current medications. Substance Storage policy diffied medications classified as see were, "subject to special disposal and record-keeping in dance with federal, state and we and regulations." The each shift change, or when did, a physical inventory of all sees is conducted by two dis documented."	F 4	31		7/12/17
	enables it to use its efficiently to attain of practicable physica well-being of each i	dministered in a manner that resources effectively and or maintain the highest I, mental, and psychosocial				

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F 490	Based on interview facility administration of abuse and mistre taken appropriate at thoroughly investig residents (R15) revaluse. The failure their abuse preven abuse was not occupotential to affect a facility. Findings include: See F225; as the faidentify potential at residents from pote investigate incidentiation to be taken. See F226; as the failure their abuse prohibition put investigate incidentiation to be taken. See F226; as the failure their abuse prohibition put investigate incidentiation to be taken. When interviewed director of nursing facility implemente the DON stated the components to the and training of new retraining of all state expected staff to know the "willful" infinity physical and verbal report abuse. The	age 95 In and document review, the confailed to ensure allegations eatment were identified timely, actions to protect residents and ate allegations for 1 of 1 viewed who alleged staff of administration to implement tion plan and ensure potential urring in the facility had all 35 current residents in the acility failed to immediately buse, take action to protect ential abuse or thoroughly to determine corrective acility failed to implement its policies and procedures to intial abuse, immediately take esidents from potential abuse stigate incidents of potential abuse trigate incidents of potential abuse prevention policy, are were numerous policy, including the screening of hires, and the annual action of harm including a labuse, and what and when to DON stated her expectation is was an allegation or suspicion	F 4	490	a. R 15 allegations were thorough investigated per policy. b. Residents educated during Res Council on 6/27/2017 on their rights responsibilities of being in a safe environment and their rights regardi Abuse Prevention/Vulnerable Adult All residents were interviewed to enthat they felt safe in the environmentall abuse allegations were investigathoroughly. c. Policy and procedure for Abuse Prevention/Vulnerable Adult Plan por reviewed and remains current. All swere educated to the Abuse Prevention/Vulnerable Adult Plan. Education on completing a thorough investigation completed administrat director of nursing, social services, assistant director of nursing. d. Administrator or Designee will complete an audit with 3 random residents, via interview, to ensure the feel safe in the facility and abuse allegations are investigated timely at thoroughly. Audits will occur weekly 4, monthly times 2 and audit results reported to QAPI committee for furtireview and recommendations.	sident sand ing the Plan. sure at and ted blicy staff or, and mey and times swill be	

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F 490	of abuse, to notify after which there winvestigation. The would include, am the resident affect interviews, review pertinent documer "protection" of the or alleged abuse, resident is safe." resident could me involved in an incident and not work until complete. The DO resident in the cort to be done "immediate most important facility, and the ba"in my opinion, ket the interview the Efacility manageme on vacation, she will call the control of the control	supervisory staff "immediately," would be the follow up DON stated investigation ong other things, interviewing ed, other residents, staff ng the care plan and other ats. The DON talked about resident if there was suspected and the need to make sure "the The DON stated protecting the an putting a staff member dent on administrative leave the investigation was DN stated the protection of the atext of an abuse situation, had diately." The DON stated that the action done daily at the sis for everything we do, was ap the resident safe." During DON stated she was part of the ant, and stated that unless away was the nurse on duty to field any allegations of abuse. When I not take more timely action in when she learned of the staff and R15, the DON stated 100% clear" picture of the "it did not register." The DON to interviewed R15 about this N stated the survey team found ang" and were were now trying	F4	90			

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F 495 SS=F	was able to identify action, and added, "they [staff] do now report. The admin R15's alleged abus stated he did not see Administrator acknows assistants, who weld id not make a report of did the facility to R15. Further, the fainvestigate R15's in to protect R15 and harm as a result of progress note about between R15 and the stated "nothing glar would have respond taking further action stated prior to surveincluding himself, dipotential abuse with protecting R15 or of administrator stated incident on 6/1/17, team's findings, he that having gone the process, stated "I we Administrator stated "to be more thorough."	d of all staff. The d, as mandated reporters, staff what abuse was and take since today's training, that know what and when to istrator also talked about e incident in early May and se a system breakdown. The owledged that the nursing re involved in R15's incident, ort or allege abuse took place, ake action to follow up with icility did not thoroughly cident, nor think to take steps other residents from potential this incident. After reading the trincident from 5/2/17, the staff, the administrator ing popped out" and stated he ded as the DON had, without in The administrator stated by team's findings staff, id not perceive a concern of in R15, nor the need of ther residents. The did not perceive a concern of the residents. The did that when he learned of the as a result of the survey took immediate action, and rough the immediate jeopardy will act differently now." The did, moving forward, we learned igh."	F 49			7/12/17
		mpetency se any individual who has months as a nurse aide in that				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY	
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F 495	facility unless the in (i) Is a full-time emitraining and competition (ii) Has demonstrated satisfactory participal nurse aide training program or competition in the satisfactory participal nurse aide training program or competition in the satisfactory participal nurse aide training program or competition. (iii) Has been deem as provided in §483. This REQUIREMED by: Based on interview facility failed to ensprovided at least 16 resident contact for (NA-G, NA-H) who This had the potent who resided at the Findings include: Nursing assistant previewed and indicated nursing assistant previewed and indicated in the providence NA-G had prior to providing displayed and indicated nursident care on 1/evidence NA-H had prior to providing displayed an interviewed and interviewed and indicated nursident care on 1/evidence NA-H had prior to providing displayed an interviewed and interviewed and indicated nursident care on 1/evidence NA-H had prior to providing displayed an interviewed and interviewed and indicated nursident care on 1/evidence NA-H had prior to providing displayed an interviewed and interviewed and indicated nursident care on 1/evidence NA-H had prior to providing displayed an interviewed and interviewed and indicated nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing displayed nursident care on 1/evidence NA-H had prior to providing display	ployee in a State-approved etency evaluation program; and competence through pation in a State-approved and competency evaluation tency evaluation program; or med or determined competent 3.150(a) and (b). Note in the contained competent and document review the competency evaluation before direct and document review the competent and document r	F 499	F 495 a. NA-G and NA-H completed netraining. b. All staff will have required training prior to providing direct care to any resident within the facility c. Education has been provided to staffing coordinator to ensure all netwires have the required training prior providing direct care to residents with facility. d. Administrator or Designee will complete an audit of a random selection of new hires to ensure proper training occurred prior to providing direct caresidents within the facility. Audits work occur weekly times 4, monthly time and audit results will be reported to committee for further review and recommendations.	ing o ew or to ithin ection ng has are to will es 2		

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F 495	nursing assistant (and started workin contact with the re- stated the personn contain certification registry before start HR-A also indicate contain evidence of before resident contain evidence of before resident contain evidence of the personnel reconcertification from the before starting direct HR-A also indicate contain evidence of training, before residents on a men that she started ha few days" after bei enrolled in a nursin certification, but did before beginning to resident contact. A audit tool titled: If from Healthcare Ac company for inservincluded records for completed by stude 5/31/17, confirmed and courses for inservince During an interview	NA)-G was hired on 3/17/17, g the floor and having direct sidents on 4/11/17. HR-A el record for NA-G did not in from the nursing assistant ting direct contact residents. d NA-G's personnel file did not if the required 16 hour training, intact. hired on 1/9/17, started to not had direct contact with g on 1/11/17. HR-A also stated and for NA-F did not contain the nursing assistant registry ect contact with the residents. d NA-F's personnel file did not if the required 16 hours of sident contact. p.m., NA-F stated that she was tor during her orientation, and wing direct patient contact "a ng hired. NA-F stated she was ng assistant class for d not have 16 hours of training of work on the floor with Facility Compliance Delano was cademy. (A web based training vice education) The tool or courses assigned out and ent between 3/1/17, and 1 that NA-F did not complete	F 4	95			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 495 F 498 SS=F	were requested, bu 483.35(c); 483.95(g DEMONSTRATE C 483.35 (c) Proficiency of No The facility must en to demonstrate con techniques necessal needs, as identified assessments, and c 483.95	pies of the employee records twere not provided. g)(1)(2)(4) NURSE AIDE COMPETENCY/CARE NEEDS urse Aides sure that nurse aides are able appetency in skills and ary to care for residents' through resident described in the plan of care. vice training for nurse aides.	F 495	5	7/12/17
	(g)(1) Be sufficient to competence of nurs than 12 hours per y (g)(2) Include demoresident abuse previous (g)(4) For nurse aid individuals with cog address the care of This REQUIREMENT by: Based on interview facility failed to proven the continuinursing assistants (reviewed who are competenced in the continuinursing assistants)	to ensure the continuing se aides, but must be no less rear. entia management training and		F 498 a. NA-C, NA-N, and NA-O were provided training (12 hours) to ensu their continued competence. b. All nursing assistants will have required training (12 hours) to ensur continued competence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245336	B. WING		06/	02/2017
	ROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CO 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 498	were reviewed and NA-C was hired on contained no evider of 12 hours of inser there was no evider evaluation. NA- N was hired on contained no evider of 12 hours of inser NA-O was hired on contained no evider of 12 hours of eductor esource assistant the files for NA-C, NHR-B were unabled documentation to comparly. Additionally, did not have a performance 2015. HR-A sonursing (DON) may an audit tool titled: was from Healthcar training company for tool included record and completed by \$5/31/17, which confidence of the contained in the	NA) personnel training files indicated: 12/2/15 The personnel file nce of successful completion vice education per year, and nce of a yearly performance 14/17/94, the personnel file nce of successful completion vice education per year. 7/12/08, the personnel file nce of successful completion ration per year. eximately 3:30 p.m. human (HR)-A and HR-B, reviewed NA-N, and NA-O. HR-A, and to present the necessary onfirm 12 hours of education the personnel file for NA-C ormance evaluation completed stated that the director of	F 498	c. Education has been pro staffing coordinator to ensur nursing assistants need to b training (12 hours) to ensure continued competence, or the removed from the schedule. d. Administrator or Design complete an audit of a randor of current employees to ensuraining hours are completed occur weekly times 4, month and audit results will be reported to ensure the committee for further review recommendations.	re all current be provided e their ney need to be ee will om selection ure required d. Audits will only times 2 orted to QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED		
		245336	B. WING		06/	06/02/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 433 COUNTY ROAD 30 DELANO, MN 55328		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 498	director of nursing assistants' records previous owner, an performance evaluand not available. A policy was requi	age 102 (DON) stated the nursing swere requested from the nd were not available. The pation for NA-C was requested ested for nursing assistant nts, none was provided.	F 4	98			

45336025

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245336 05/31/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 433 COUNTY ROAD 30 THE ESTATES AT DELANO LLC **DELANO, MN 55328** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/29/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 00933

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		PLETED
		245336	B. WING			05/3	31/2017
	PROVIDER OR SUPPLIER	_c		4	TREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF T A G		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or processors of the second of the sec	tate.mn.us and n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done		000	DEFICIENCY		
	corridors that is modepartment notification. The facility has a continuous c	onitored for automatic fire			a		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY PLETED
		245336	B. WING_		05/3	31/2017
	PROVIDER OR SUPPLIER TATES AT DELANO LI	_c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	NOT MET as evide NFPA 101 Fire Alarm - Out of Where required fire services for more to period, the authority notified, and the bust approved fire watch parties left unprote fire alarm system in 9.6.1.6 This STANDARD Based on docume the Facility failed to accurate Fire Alarm deficient practice or residents. Fire Alarm - Out of Where required fire services for more to period, the authority notified, and the bust approved fire watch parties left unprote fire alarm system in 9.6.1.6 Findings include: On the facility tour on 05/31/2017, doct that the Out of Ser System was unavailable.	t 42 CFR, Subpart 483.70(a) is enced by: rm System - Out of Service Service e alarm system is out of than 4 hours in a 24-hour y having jurisdiction shall be eviliding shall be evacuated or an an shall be provided for all cted by the shutdown until the has been returned to service. It is not met as evidenced by: Intation review and interview, or provide a current and in Out of Service Policy. The ould affect 35 out of 35	K 00		ed in the aclude all that the sen a 24 hour e now of the l ano ludes the ctor and the eventule om the ey the em is eved fire all building a til the fire	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED
		245336	B. WING		05/31/2017
	PROVIDER OR SUPPLIER	LC	4	STREET ADDRESS, CITY, STATE, ZIP CODE 133 COUNTY ROAD 30 DELANO, MN 55328	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 354	NFPA 101 Sprinkle	age 3 pervisor and Administrator. er System - Out of Service	K 346	b. Maintenance Director or designensure that when all future mainter to the fire alarm system is conducte Summit Companies, or another apvendor, on the fire alarm and sprint system that the Fire Alarm System Out-of-Service policy and procedur followed as required by NFPA 101. c. Education will be provided to Environmental Services, Maintenant and Administration to ensure compof the Fire Alarm System Out-of-Service policy consistent with the requirem outlined by NFPA 101. d. Administrator or designee will the request the Maintenance Direct receive prior approval by the Admin or designee before conducting any updates, repairs, or preventative maintenance on either the Fire Ala System or the Fire Sprinkler System ensure compliance with the Out-of-Service Policy and Procedut the Fire Alarm System Out-of-Service policy and procedure requirements outlined by NFPA 101.	nee will nance ed by proved kler e is nce, diance ervice ents require tor to nistrator m m to re for ice
SS=C	Sprinkler System - Where the sprinkle extent and duration determined, areas inspected and risk	er system is impaired, the n of the impairment has been or buildings involved are		*	

Event ID: BBZQ21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 0 1	(X3) DATE SURVEY COMPLETED
		245336	B. WING		05/31/2017
	PROVIDER OR SUPPLIER	_c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	BE COMPLETION
K 354	department and oth jurisdiction have be sprinkler system is hours in a 24-hour of the building affect approved fire watch system has been red. 18.3.5.1, 19.3.5.1, This STANDARD is Based on docume the Facility failed to accurate Fire Sprindeficient practice consideration. Sprinkler System - Where the sprinkler extent and duration determined, areas inspected and risks recommendations or designated reprodepartment and oth jurisdiction have be sprinkler system is 10 hours in a 24-hoportion of the build an approved fire we sprinkler system had 18.3.5.1, 19.3.5.1, Findings include: On the facility tour on 05/31/2017, doct that the Out of Service watch signal to the service was a service with the service was a service was a service was a service was a service with the service was a service was	esentative, and the fire her authorities having sen notified. Where the out of service for more than 10 period, the building or portion of the are evacuated or an is provided until the sprinkler eturned to service. 9.7.5, 15.5.2 (NFPA 25) is not met as evidenced by: intation review and interview, in provide a current and obtain out of Service Policy. The ould affect 35 out of 35. Out of Service in system is impaired, the in of the impairment has been or buildings involved are.	К3	K 354 a. Sprinkler System Out-of-Service Policy and Procedure was updated Maintenance Director binder to incomo fithe required steps in the event it sprinkler system needs to be taken or if it is impaired in any way for m 10 hours in a 24 hour period. If the sprinkler system is impaired or offextent and duration of the impairm off-line status will be determined, it areas of the building involved will be inspected and risks will be determ Recommendations will be submitted management or designated representative, and the Deputy State Marshall Inspector and any other jurisdiction entity over The Estates Delano Skilled Nursing Facility will notified as required by NFPA 101. In the event the sprinkler system is to taken off-line all parties will eithe evacuated from the facility that are unprotected by the shutdown until building fire sprinkler system is reference. Or an approved fire wate conducted to protect all parties chi	I in the lude all hat the n off-line ore than eline, the ent or he oe ined. ed to e Fire at be needs to her be eleft the turned to h will be

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		SURVEY PLETED
		245336	B. WING		_ 05/3	31/2017
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STA 433 COUNTY ROAD 30 DELANO, MN 55328	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
K 354		age 5 etice was verified by the pervisor and Administrator.	K 3	all areas of the build every 30 minutes un system is back on-ling functioning. b. Maintenance Diensure that when all to the building fire system of alarm and sprinkler Sprinkler System Of and procedure is fol NFPA 101. c. Education will be Environmental Servand Administration to fithe Sprinkler Alar Out-of-Service policing requirements outlined. d. Administrator of the request the Main receive prior approvor designee before updates, repairs, or maintenance on eith System or the Fire sensure compliance.	rector or designee will future maintenance prinkler system is nit Companies, or endor, on the fire system that the ut-of-Service policy lowed as required by e provided to ices, Maintenance, to ensure compliance or System by Consistent with the ed by NFPA 101. In designee will require intenance Director to val by the Administrator conducting any preventative intenance Pire Alarm Sprinkler System to with the cy and Procedure for inkler System cy and Procedure	
K 521 SS=F	HVAC	n, and air conditioning shall	K		,	7/17/17

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245336	B WING			05/3	1/2017
	PROVIDER OR SUPPLIER	_c		43	REET ADDRESS, CITY, STATE, ZIP CODE 3 COUNTY ROAD 30 ELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 521		d shall be installed in e manufacturer's	K 5	521			
	Based on observa revealed that the far part of the air distrimake-up air for the exhaust, throughou accordance with N practice could allow to travel far from the affect all residents,	is not met as evidenced by: tions and an interview, it is acility is using the corridors as bution system to provide a sleeping rooms' bathroom at the building which is not in FPA 90A. This deficient by the products of combustion are fire origin and negatively staff and visitors by restricting tess in a fire situation.			a. The Estates of Delano would I request for an updated waiver for to 31-2017 Life Safety Code Inspecting Estates at Delano, previously known Golden Living Center Delano #008 an approved waiver the year prior North and South corridors using the corridors as part of the heating very and air conditioning air distribution to provide make-up air for both respectively.	the 05- on. The yn as 674, had for both e ntilation, system sident	
	on 05/31/2017, obstheating, ventilation for the building is upart of the air distrifor the bathrooms. This deficient pract	between 8:00 am to 12:00 pm servations revealed that the , and air conditioning systems using the corridor system as bution system for make-up air exhaust.			rooms and bathrooms. Compliand this provisions as identified in K52 impose an unreasonable hardship facility due to the disruption during weeks of construction to the corridleading to all the resident rooms. Additionally, the electrical system building would need to be upgrade handle the power load requirementair handling system. And the structure integrity of the building would pote be compromised by the installation	1 would on the the 6 dors in the ed to ts of the ctural ntially n of the	
V 740		vas previously granted.	IV -	710	required equipment. (See Attache Update Waiver Request for NFPA HVAC)		7/17/17
K 712	NFPA 101 Fire Dril	15	, r	712			(/1//1/

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00933

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245336 B. WING 05/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 THE ESTATES AT DELANO LLC **DELANO, MN 55328** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 712 Continued From page 7 K 712 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: K 712 Based on record review and staff interview the facility failed to provide documentation of fire drills a. Fire drills that include the at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, transmission of a fire alarm signal and simulation of emergency fire conditions. section 19.7.1.4 to 19.7.1.7. This deficient Fire drills are held at unexpected times practice could reduce the ability of staff to under varying conditions, at least quarterly conduct a safe and timely response to a fire on each shift. The staff is familiar with emergency, which would affect all 35 residents procedures and is aware that drills are and an undetermined amount of staff and visitors. part of established routine. Responsibility for planning and conducting drills is Findings include: assigned only to competent persons who are qualified to exercise leadership. On the facility tour between 8:00 am to 12:00 pm on 05/31/2017 record review and staff interview Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement revealed one fire drill was done on the wrong shift may be used instead of an audible alarm. in the third quarter of 2016. b. An audit system has been established to ensure that the required fire drills will be This deficient practice was verified by the conducted at unexpected times, under Housekeeping Supervisor and Administrator. varying conditions, and on each shift a minimum of quarterly in compliance with the requirements of NFPA 101 Fire Drills.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01	COMF	PLETED
		245336	B. WING _		05/3	31/2017
	PROVIDER OR SUPPLIER	c		STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX T A G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920		age 8	K 71	c. The Administrator or designee audit the Maintenance Director to a compliance with the requirement of drills conducted at unexpected time under varying conditions, and on e shift a minimum of quarterly in conwith the requirements of NFPA 101 Drills. d. The Maintenance Director and Administrator or designee will presequired quarterly fire drills alternate each shift to the monthly QAPI metersure compliance with the required guidelines for Fire Drills as outlined NFPA 101 for Fire Drills.	ensure or fire es, ach appliance I Fire eent the ting eting to ed	7/17/17
SS=D	Extension Cords Power strips in a paused for componer patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power st may not be used for electronics), excep rooms that do not u PCREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All pow precautions. Exter substitute for fixed	atient care vicinity are only nts of movable delectrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal t in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL ver strips are used with general asion cords are not used as a wiring of a structure.				

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245336 B. WING 05/31/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 433 COUNTY ROAD 30 THE ESTATES AT DELANO LLC **DELANO, MN 55328** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 920 Continued From page 9 K 920 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview the K 920 facility failed to ensure a multiple outlet connection was in accordance with the 2012 a. The power strip plugged into a refrigerator in room 3B that was plugged edition of NFPA 99 section 10.2.3.6 item 2 for into another power strip before reaching total ampacity. This deficient practice could cause the wall outlet was removed. Also, the an overload of a circuit which could cause a medical equipment in room 3B that was power outage to necessary equipment or cause a plugged into a power strip was plugged fire. This could affect 15 of the 35 residents and directly into the wall outlet as required by an undetermined amount of staff and visitors. NFPA 101 for Electrical Equipment -Power Cords and Extension Cords. Findings include: Power strips in a patient care vicinity are only used for components of movable On the facility tour between 8:00 am to 12:00 pm on 05/31/2017 observations and staff interview patient-care-related electrical equipment (PCREE) assembles that have been revealed in resident room 3B a refrigerator assembled by qualified personnel and plugged into a power strip and into another power meet the conditions of 10.2.3.6. Power strip and not directly into a wall outlet. Medical strips in the patient care vicinity may not equipment was also plugged into the power be used for non-PCREE, except in strips. long-term care resident rooms that do not use PCREE. Power strips for PCREE This deficient practice was verified by the meet UL 1363A or UL 60601-1. Power Housekeeping Supervisor and Administrator. strips for non-PCREE in patient care rooms (outside of vicinity) meet UL 1363. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. b. All resident rooms in the facility will be audited for non-compliance with the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - Main Building 01	(X3) DATE COMF	SURVEY PLETED
		245336	B. WING	_		05/3	31/2017
	PROVIDER OR SUPPLIER TATES AT DELANO LL	.c	"	4	TREET ADDRESS, CITY, STATE, ZIP CODE 33 COUNTY ROAD 30 DELANO, MN 55328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	Continued From pa	age 10	KS	920	requirements as outlined by NFPA Electrical Equipment – Power Cord Extension Cords. Any identified visof the Electrical Equipment – Power and Extension Cord requirements immediately resolved for all residence. C. Education will be provided to a relating to the requirements outline NFPA 101 for Electrical Equipment Power Cords and Extension Cords monitor future compliance. d. The Maintenance Director or designee will conduct a NFPA 101 Electrical Equipment – Power Cord Extension Cords audit of 5 resident weekly and presented to the QAPI meeting monthly. The frequency will be adjusted depending on the of the audit.	ds and colations er Cord will be nts. Ill staff ed by to	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

K521 PROVISION NUMBER(S) and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is Waiver Request for May 31, 2017 Life Safety Code Inspection. Waiver request submitted on June 27, 2017. Currently, The Estates at Delano is using the corridors for both North and South wings as part of the heating, ventilation, JUSTIFICATION

- being requested for the following reasons: shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or because the building is equipped with an approved full smoke detector system, along with an automated full There will be no adverse effect on the health and safety of the facility's residents, family members, and staff
- The facility is protected by a 24 hour supervised automatic sprinkler system. sprinkler system.
- SIN designated exterior smoking area on the far end of the patio in the back of the building, used only by a few The internal facility is smoke-free and signs are prominently posted at all major entrances/exits. There is a 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 The building fire alarm system is monitored to provide automatic fire department notification.
- 6 5 Fire safety training is provided for all employees on an annual basis and during orientation for all new hires
- Fire drills are conducted quarterly on each shift.
- The Estates at Delano was not able to find a more cost effective solution for making the ventilation system upgrades to 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during bid also proposed the installation of duct work that would negatively affect the structural integrity of the building building would need to be upgraded to handle the power load requirements of the air handling system. The initial

meet the current codes NFPA 90A. Submitted by: Don Flack, Administrator - June 27,2017

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date
	PILLE SAFETY SURENVISOR	PLACE SAFRETY SURGAUSOR STATE FLACE MARSHAL	0 1 - 24 - 1 1 Page 26
Form CMS-2786R (03/04) Previous Versions Obsolete	(€		

K 521

corridors as part of the heating ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and previously known as Golden Living Center Delano #00874, had an approved waiver the year prior for both North and South corridors using the The Estates of Delano would like to request for an updated waiver for the 05-31-2017 Life Safety Code Inspection. The Estates at Delano, to be upgraded to handle the power load requirements of the air handling system. And the structural integrity of the building would potentially be during the 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need bathrooms. Compliance with this provisions as identified in K521 would impose an unreasonable hardship on the facility due to the disruption compromised by the installation of the required equipment. (See Attached Update Waiver Request for NFPA 101 HVAC)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 20, 2017

Mr. Don Flack, Administrator The Estates At Delano LLC 433 County Road 30 Delano, MN 55328

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5336026

Dear Mr. Flack:

The above facility was surveyed on May 30, 2017 through June 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

The Estates At Delano LLC June 20, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338 or brenda.fischer@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health Email: kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 07/08/2017 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 06/29/17

TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
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2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to element of the Minnesota Department on May 30, 2017 the surveyors of this Deabove provider and orders are issued, electronic plan of coreviewed these ordered they will be completed Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The state of the Stat	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Irough June 2, 2017, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. In ent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes th	2 000			
	FOURTH COLUMN "PROVIDER'S PLA					

Minnesota Department of Health

STATE FORM BBZQ11 If continuation sheet 2 of 73

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 185	MN Rule 4658.0060 Administrator; repo	D. A. Responsibilities of rts	2 185			7/17/17
		s responsible for the: ompletion, and submission of s as required by the				
	by: Based on interview facility administration of abuse and mistre taken appropriate a thoroughly investigatesidents (R15) rev abuse. The failure of their abuse prevent abuse was not occupotential to affect al facility. Findings include: See F225; as the fail dentify potential ab residents from pote	and document review, the on failed to ensure allegations eatment were identified timely, actions to protect residents and ate allegations for 1 of 1 iewed who alleged staff of administration to implement ion plan and ensure potential arring in the facility had II 35 current residents in the actility failed to immediately use, take action to protect ential abuse or thoroughly is to determine corrective		Corrected		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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2 185	Continued From pa	ige 3	2 185			
	See F226; as the facility failed to implement its abuse prohibition policies and procedures to timely identify potential abuse, immediately take actions to protect residents from potential abuse or thoroughly investigate incidents of potential abuse. When interviewed on 6/2/17 at 9:59 a.m., the director of nursing (DON) discussed how the facility implemented its abuse prevention policy. The DON stated there were numerous components to the policy, including the screening and training of new hires, and the annual retraining of all staff. The DON stated she expected staff to know and identify abuse, which was the "willful" infliction of harm including physical and verbal abuse, and what and when to report abuse. The DON stated her expectation is that anytime there was an allegation or suspicion of abuse, to notify supervisory staff "immediately," after which there would be the follow up investigation. The DON stated investigation would include, among other things, interviewing the resident affected, other residents, staff interviews, reviewing the care plan and other pertinent documents. The DON talked about "protection" of the resident if there was suspected or alleged abuse, and the need to make sure "the resident is safe." The DON stated protecting the resident could mean putting a staff member involved in an incident on administrative leave and not work until the investigation was complete. The DON stated the protection of the resident in the context of an abuse situation, had to be done "immediately." The DON stated that the most important action done daily at the facility, and the basis for everything we do, was "in my opinion, keep the resident safe." During the interview the DON stated she was part of the facility management, and stated that unless away					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED				
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	433 COUNTY ROAD 30								
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2 185	on vacation, she way calls were there any asked why she did regarding to R15 wincident between sty she did not get a "1 situation, and that " stated she had not incident. The DON "something alarming to keep the resident During interview on administrator talked prohibition policy were sponsibility for the administrator descripting, backgroun and training require administrator stated was able to identify action, and added, "they [staff] do now report. The admin R15's alleged abus stated he did not see Administrator acknown assistants, who we did not make a repond did the facility to R15. Further, the fainvestigate R15's in to protect R15 and harm as a result of progress note about between R15 and the stated "nothing glar would have respondating further action"	as the nurse on duty to field y allegations of abuse. When not take more timely action in hen she learned of the aff and R15, the DON stated 00% clear" picture of the it did not register." The DON interviewed R15 about this stated the survey team found g" and were were now trying ts safe. 6/2/17 at 4:32 p.m., the d about how the facility's abuse orked and of his ultimate e residents in the facility. The ibed pre-employment finger d screening, job shadowing,							

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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THE ESTATES AT DELANOLLO 433 COUN			DRESS, CITY, S NTY ROAD 3 MN 55328	STATE, ZIP CODE O		
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2 185	including himself, d potential abuse with protecting R15 or o administrator stated incident on 6/1/17, team's findings, he that having gone th process, stated "I w Administrator stated "to be more thorough SUGGESTED MET facility board of direct policies and proced administrator's role The BOD could eduhis/her role and residevelop monitoring compliance.	id not perceive a concern of n R15, nor the need of ther residents. The d that when he learned of the as a result of the survey took immediate action, and rough the immediate jeopardy vill act differently now." The d, moving forward, we learned gh." THOD OF CORRECTION: The ectors (BOD) could review its	2 185			
2 265	A nursing home mupolicies to guide staphysicians, physiciapractitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the	2 265			7/17/17

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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2 265	Continued From pa	ge 6	2 265			
	A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;					
	C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;					
	D. a decision to transfer or discharge the resident from the nursing home; or					
	E. expected and unexpected resident deaths.					
	This MN Requirement is not met as evidenced by: Based on interview and document review the facilty failed to notify the physician following the development of two pressure ulcers for 1 of 3 residents (R18) reviewed for pressure ulcers. In addition, the facility failed to notify the residents responsible party of a room change for 1 of 3 residents (R12) reviewed for room transfers. Findings include: LACK OF NOTICE WITH CHANGE IN CONDITION R18's admission Minimum Data Set (MDS), dated 3/22/17, indicated R18 required extensive assistance with bed mobility and transfers. The MDS identified R18 was at risk for pressure			Corrected		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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2 265	O0933 F PROVIDER OR SUPPLIER STATES AT DELANO LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		2 265			

Minnesota Department of Health

STATE FORM BBZQ11 If continuation sheet 8 of 73

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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Minnesota Department of Health

STATE FORM BBZQ11 If continuation sheet 9 of 73

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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2 265	Continued From pa	ge 9	2 265			
	director of nursing (develop systems fo DON or designee of facility practices, po notifications of char could develop moni ongoing compliance the quality assurance	THOD OF CORRECTION: The (DON) or designee could report rotification of change. The ould inservice staff regarding plicy and procedures for age. The DON or designee storing systems to ensure e and report those results to be committee. R CORRECTION: Twenty-one				
2 300	MN Rule 4658.0105	5 Competency	2 300			7/17/17
	are able to demons techniques necessa needs, as identified resident assessmen	ist ensure that direct care staff trate competency in skills and ary to care for residents' I through the comprehensive ints and described in the in of care, and are able to ned duties.				
	by: Based on interview facility failed to provensure the continuinursing assistants (reviewed who are continuinursing assistants)	and document review, the vide inservice training to ng competence of 3 of 5 (NA-C, NA-N, and NA-O) currently employed. This had ect all 35 residents who reside		Corrected		
	Nursing assistant (Nursing assis	NA) personnel training files indicated:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
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2 300	NA-C was hired on contained no evider of 12 hours of inser there was no evider evaluation. NA- N was hired on contained no evider of 12 hours of inser NA-O was hired on contained no evider of 12 hours of eductor esource assistant of the files for NA-C, NHR-B were unabled documentation to concept of the files for NA-C, NHR-B were unabled documentation to concept of the files for NA-C, NHR-B were unabled documentation to concept of the files for NA-C, NHR-B were unabled documentation to compare to the files for NA-C, NHR-B were unabled documentation to compare the files for NA-C, NHR-B were unabled to	12/2/15 The personnel file nee of successful completion vice education per year, and nee of a yearly performance 1.4/17/94, the personnel file nee of successful completion vice education per year. 7/12/08, the personnel file nee of successful completion ation per year. ximately 3:30 p.m. human (HR)-A and HR-B, reviewed NA-N, and NA-O. HR-A, and to present the necessary onfirm 12 hours of education the personnel file for NA-C ormance evaluation completed tated that the director of	2 300			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
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2 300	training requirement SUGGESTED MET director of nursing (develop systems to in place for staff ho The DON or design appropriate staff on designee could devensure ongoing corresults to the quality TIME PERIOD FOR (21) days.	sted for nursing assistant ts, none was provided. CHOD OF CORRECTION: The (DON) or designee could ensure appropriate training is lding certifications/licensure. He could educate all those systems. The DON or elop monitoring systems to impliance and report those y assurance committee. R CORRECTION: Twenty-one	2 300			
2 435	Assignments Room assignment must develop and in procedures for addinctuding complaint and roommates. A procedures must in A. a mechanism resolution of room complaints; and B. a procedure and its resolution.	n for informal dispute assignment and roommate for documenting the complaint	2 435			7/17/17
	by: Based on interview facility failed to ens reviewed for admis-	and document review, the ure 1 of 5 residents (R22) sion, transfer and discharge ed timely prior to a change in		Corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 435	Continued From pa	ge 12	2 435			
	roommate.					
	Findings include:					
	R22's annual Minimum Data Set (MDS) dated 4/12/17, identified R22 had intact cognition.					
	stated he had a roo several months and just bring them in."	5/30/17, at 11:33 a.m. R22 ommate change within the past d was not notified prior, "[Staff] R22 stated he would have notice of a new roommate arrive.				
	R22's progress notes dated 3/22/17, to 3/28/17, identified the following entry on 3/27/17, at 11:46 p.m. "[R22] got a roommate today, and isn't happy about this." R22 was documented as having called the new roommate several names, and complained to other residents about him. There was no documented evidence in the progress notes R22 was provided any notice of a roommate coming prior to this entry.					
	any documentation	rd was reviewed and lacked to demonstrate R22 had been v roommate prior to their				
	licensed social wor used, "Room chang when they are getti LSW-A stated she R22's recent room stated she spoke w staff and the docun upset, "shows he w one." Further, LSW	on 6/1/17, at 8:54 a.m. ker (LSW)-A stated the facility ge forms" to alert residents ang a roommate; however, was unable to locate this for mate change in 3/17. LSW-A with the corporate consultant nented note of him being was informed he was getting V-A stated the facility had no e R22 was told prior to the new				

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06/0	2/2017
ON LD BE PRIATE	(X5) COMPLETE DATE
	7/17/17
	D BE

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION :		E SURVEY PLETED	
		00933	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER	C 433 COU	DDRESS, CITY, NTY ROAD; , MN 55328	STATE, ZIP CODE 30		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 565	This MN Requirements by: Based on observation review, the facility for planned intervention residents (R24) review residents (R75, R25 smoking and/or was failed to follow the promotion for 1 of pressure ulcers. Findings include: R24's annual Minimal 4/19/17, indicated Fimpairment. The Minimal Minima	ent is not met as evidenced on, interview and document ailed to implement care ns to prevent injury for 1 of 2 iewed for falls, and 2 of 2 7) reviewed for safety with ndering. Further, the facility blan of care for wound 3 residents (R44) reviewed for care for wound care for wound care for wound care for wound developed the facility blan of care for wound care cognitive developed the facility care and anxiety. The care needed extensive assistance nsfers, and ambulation and care needed extensive assistance nsfers, and ambulation and care needed 1/25/17. care on 3/8/17, indicated a care don 3/8/17, indicated a care don 3/8/17, indicated a care don 3/8/17, indicated a care for wound care needed extensive assistance in needed extensive in	2 565	Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B W/N/0			
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE EST	ATES AT DELANO LI	C	ITY ROAD 3 MN 55328	U		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	nge 15	2 565			
	from a laceration on his head.					
	During observation on 5/31/17, at 7:37 p.m. R24 was lying in bed. There was no fall matt by the bedside.					
	assistant NA-H stat floor as directed. N	to 5/31/17, at 7:56 p.m. nursing ted the fall matt was not on the A-H looked for the fall matt t. NA-H left the room and went ident.				
	During interview on 5/31/17, at 8:06 p.m. trained medication aid (TMA)-A stated that R24 needed to have a fall matt at his bedside. TMA-A found the fall matt behind the door and placed it on the floor.					
	director of nursing information charted didn't sound as if the The DON further st	6/2/17, at 10:33 a.m. the (DON) stated, based on the don the fall dated 5/11/17, it he fall matt was on the floor. Stated assessed fall expected to be followed.				
	WANDERGUARD:					
	moderate cognitive	DS dated 2/21/17, identified impairment and wandering ced him at risk for getting to a us place.				
	at risk for elopement leaving the facility a were to have no inc					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER		L DRESS, CITY, S	STATE, ZIP CODE	1 00/0	2/2017
	ATES AT DELANO LI	433 COUN	ITY ROAD 3	•		
THE EST		DELANO,	MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page 16		2 565			
	During observation on 5/31/17, at 1:33 p.m. R75 was outside on the smoking patio having a cigarette. R75 did not have a Wanderguard on.					
	lying in his bed on t clothed. He was w have a Wandergua	5/31/17, at 7:17 p.m. R75 was top of the blankets, fully atching television. R75 did not rd on. The Wanderguard was side table, however, the band rd was broken.				
	stated he used to w wrist, but the band several weeks ago the band had broke one had fixed it or o stated sometimes h	o 5/31/17, at 7:18 p.m. R75 wear a Wanderguard on his on the Wanderguard broke . R75 stated he told the staff en on the Wanderguard, but no given him a new one. R75 he kept the Wanderguard in his coat pocket, but not always.				
	TMA-A stated R75 p.m. TMA-A went to Wanderguard sittin	on 5/31/17, at 7:26 p.m. wore a Wanderguard. At 7:30 o R75's room and found the g on his bedside table. TMA-A have it attached to his body ne bedside table.				
	stated R75 was an Wanderguard locat	on 6/1/17, at 7:54 a.m. NA-K elopement risk and wore a red on his wheelchair. During , at 8:04 a.m. NA-J stated R75 nderguard.				
	director of nursing staff to follow a resifurther stated, not h	on 6/1/17, at 12:18 p.m. the (DON) stated she expected ident's care plan. The DON naving the Wanderguard as considered not following the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00933	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER	C 433 COU	DDRESS, CITY, ST NTY ROAD 30 , MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	SMOKING: R75's admission M 2/21/17, identified F impairment, require activities of daily liv any tobacco product Report identified ar "Tobacco Use." R75's care plan dat "Resident currently included a goal for safely." The care p included, "Independevaluation," and, "S R75's Smoking Evaluation indicated evaluation indicated evaluation indicated equipment which in Further, the evaluation accepting of wearing accepting of facility During observation went outside to the wheelchair. He had apron on his lap. The smoking, the safety lap. There were not he smoked. When observed on sitting by the nurse' cigarettes. Staff ha lighter, and a smok himself outside to the	inimum Data Set (MDS) dated R75 had moderate cognitive ed limited assistance with ing (ADLs) and did not use ets. R75's undated Diagnosis in admitting diagnosis of, ted 3/22/17, indicated smokes at this facility," and R75 of, "Resident will smoke plan listed interventions which dent with smoking per smoking apron per evaluation." aluation dated 3/10/17, cognitive loss and a visual two to five times per day. The draw to five times per day. The draw to five times per day. The draw to five times per day as moking apron."				

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NAME OF PROVIDER OR SUPPLIER THE ESTATES AT DELANO LLC SIRVER CASH DESCRIPTION OF DELANO, MN 55328 PROVIDER PLAN OF CORRECTION OF LAND, MN 55328 PROVIDER PLAN OF CORRECTION OF LAND OF LAND, MN 55328 PROVIDER PLAN OF CORRECTION OF LAND OF LAND, MN 55328 PROVIDER PLAN OF CORRECTION OF LAND OF LAND OF LAND, MN 55328 PROVIDER PLAN OF CORRECTION OF LAND OF LAND OF LAND OF CORRECTION OF LAND OF LA	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
SUMMARY STATEMENT OF DEFICIENCIES MIN 55328 DELANO, MN 55328			00933	B. WING		06/0	2/2017
CALL DELANO LLC DELANO, MN 55328	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 18 1:31 p.m. a nursing assistant (NA)-L went outside to the smoking patio and told R75 he must have his apron on to be outside smoking, NA-L placed the smoking paron on R75 and then went back inside the facility. During interview on 5/31/17, at 1:33 p.m. R75 stated sometimes he wore the smoking apron on his lap. When interviewed on 5/31/17, at 7:23 p.m. NA-H stated R75 stade to wear a smoking apron when he was smoking, but did not believe R75 needed a staff member to be outside with him when he smoked. During interview on 6/11/17, at 7:26 p.m. trained medication aide (TMA)-A stated for extra safety, residents had to wear a smoking apron. During interview on 6/11/17, at 8:35 a.m. licensed practical nurse (LPN)-A stated R75 had to wear an apron when he smoked per his smoking apron is supposed to be worn around his neck, but R75 often just placed the smoking apron or sis supposed to be worn around his neck, but R75 often just placed it on his lap. LPN-A stated R75 should be wearing the smoking apron over his neck so it covered his chest and body and not just be folded on his lap. On 6/1/17, at 12:18 p.m. the director of nursing (DON) stated she expected staff to follow the care plan for each resident. The DON further stated not using the smoking the smoking apron for R75 was	THE EST	ATES AT DELANO LL	C		0		
1:31 p.m. a nursing assistant (NA)-L went outside to the smoking patio and told R75 he must have his apron on to be outside smoking. NA-L placed the smoking apron on R75 and then went back inside the facility. During interview on 5/31/17, at 1:33 p.m. R75 stated sometimes he wore the smoking apron and sometimes he did not, depending on how he felt. R75 stated he typically just placed the smoking apron on his lap. When interviewed on 5/31/17, at 7:23 p.m. NA-H stated R75 had to wear a smoking apron when he was smoking, but did not believe R75 needed a staff member to be outside with him when he smoked. During interview on 5/31/17, at 7:26 p.m. trained medication aide (TMA)-A stated for extra safety, residents had to wear a smoking apron. During interview on 6/1/17, at 8:35 a.m. licensed practical nurse (LPN)-A stated R75 had to wear an apron when he smoking evaluation. LPN-A also added the smoking apron is supposed to be worn around his neck, but R75 often just placed it on his lap. LPN-A stated R75 should be wearing the smoking apron over his neck so it covered his chest and body and not just be folded on his lap. On 6/1/17, at 12:18 p.m. the director of nursing (DON) stated she expected staff to follow the care plan for each resident. The DON further stated not using the smoking apron for R75 was	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETE
R27's admission Minimum Data Set (MDS) dated	2 565	1:31 p.m. a nursing to the smoking patinis apron on to be of the smoking apron inside the facility. During interview on stated sometimes he and sometimes he felt. R75 stated he smoking apron on he when interviewed of stated R75 had to was smoking, but of staff member to be smoked. During interview on medication aide (TI residents had to we be a supposed to be worth of the process of the proc	assistant (NA)-L went outside o and told R75 he must have outside smoking. NA-L placed on R75 and then went back 5/31/17, at 1:33 p.m. R75 he wore the smoking apron did not, depending on how he typically just placed the his lap. on 5/31/17, at 7:23 p.m. NA-H wear a smoking apron when he lid not believe R75 needed a outside with him when he 5/31/17, at 7:26 p.m. trained MA)-A stated for extra safety, ear a smoking apron. 6/1/17, at 8:35 a.m. licensed N)-A stated R75 had to wear smoked per his smoking also added the smoking apron worn around his neck, but R75 on his lap. LPN-A stated R75 the smoking apron over his his chest and body and not is lap. 1 p.m. the director of nursing expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident. The DON further expected staff to follow the resident.	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00933	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER FATES AT DELANO LL	C 433 COUI	DRESS, CITY, S NTY ROAD 30 , MN 55328	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	and indicated R27 of products. R27's care plan dat currently smoking with R27's care planned smoke safely." Fur interventions includ outside to smoke," evaluation." R27's Smoking Evaindicated R27 was and listed, "Facility need for adaptive eplaced next to, "Smiskin and clothes to ashes]." During observation came to the nursing folded up gray color three single cigaret nurse (LPN)-E. R2 using his walker. R2 smoking apron on the proceeded to light have them. R27 stated them.	currently used tobacco sed 4/20/17, identified R27 was while at the nursing home. I goal was, "Resident will ther, the care plan listed ing, "Use walker while going and, "Smoking apron per aluation Form dated 5/25/17, able to smoke independently specific interventions including quipment," with a written, "X" toking apron [device covering prevent burns from dropped on 5/30/17, at 1:34 p.m. R27 g station and was provided a red smoking apron, lighter and tes from licensed practical 7 then ambulated outside 27 placed the folded up the table outside and sis cigarette(s) and smoke the staff was aware he was not ed smoking apron but had,	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00933	B. WING		06/0	2/2017	
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, ST				
THE ESTATES AT DELANO LLC		NTY ROAD 30 MN 55328				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
plans were used to, "Ingetting their independence were expected to follow stated R27 should be directed by his evaluated R24's annual Minimum 4/26/17, identified R4 impairment, required activities of daily living stage III (described as pressure ulcer and resulcer development. R44's care plan dated a pressure ulcer due incontinence and limit identified R44 had a culcer on his buttock a complete, "Weekly we "Conduct weekly skin During observation or licensed practical nur R44's dressing changer outinely measure the changes as, "that's or LPN-C completed no collection of R44's pressinged or responsitions."	nursing (ADON) stated care make sure every resident is dent needs met," and staff ow it. The ADON further e using the smoking apron as ation and care plan. E WOUND MONITORING: In Data Set (MDS) dated and moderate cognitive extensive assistance with g (ADLs), had a current stull thickness tissue loss) emained at risk for pressure and directed staff to ound assessment," and, inspection." In 6/2/17, at 9:57 a.m. are (LPN)-C completed ge. LPN-C stated she did not be ulcer with dressing any scheduled or whatever." measurements/data essure ulcer. In 6/2/17, at 10:26 a.m. as unaware who was ble to measure and stics of pressure ulcers. aff only measure the cited to do so by the	2 565				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER FATES AT DELANO LL	C 433 COUI	DRESS, CITY, S NTY ROAD 30 MN 55328	STATE, ZIP CODE 0		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	R44's TAR dated 4/staff, "Complete We [Monarch Health Mewound Evaluation] wound." This was a weekly basis on 45/17/17, 5/24/17 an 5/3/17, the entry wa home," and on 5/10 as, "Drug refused." was recorded as, "CR44's MHM Weekly 4/30/17, 5/1/17, 5/1 R44 had a stage III Additionally, the evaluations fur wound clinic. Althou data, there was no assessment as directly characteristics had a weekly basis as densure healing. When interviewed of director of nursing (were responsible to R44's pressure ulce	25/17, to 5/30/17, directed eekly wound evaluation anagement (MHM) Weekly under forms tab for coccyx scheduled to be completed on 1/26/17, 5/3/17, 5/10/17, d 5/31/17. However, on as recorded as, "Absent from 1/17, the entry was recorded Further, on 5/17/17, the entry Other / See Nurses Notes." If Wound Evaluation dated 9/17, and 5/30/17 identified pressure ulcer on his coccyx. aluations contained he stage III pressure ulcer. ther identified R44 visited a ugh evaluations contained comprehensive weekly wound ected by the plan of care. If was reviewed. There was nentation identified to pressure ulcer and associated been monitored/assessed on lirected by the care plan and to 1/17, at 11:35 a.m. the 1/17, at 11:35 a.m.	2 565	DEFICIENCY)		
	electronic medical r R44's medical reco ulcer had not been have been, "for con	nd Evaluation form(s) in the record. The DON reviewed rd and stated his pressure tracked weekly, but should attinued monitoring to ensure a." and R44's. "treatment				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00933	B. WING		06/02/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE EST	ATES AT DELANO LL	C	ITY ROAD 3 MN 55328	0			
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2 565	Continued From pa	ge 22	2 565				
	[was] still effective."						
		mplementation of the care plan none was provided.					
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee develop systems to ensure individualized resident care plans are followed. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations.						
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			7/17/17	
	receive nursing car custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursiof bed as much as written order from to	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the hin in bed or the resident bed.					
	by:	ent is not met as evidenced on, interview and document		Corrected			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 23 review, the facility failed to follow existing fall interventions and comprehensively assess falls to identify the root cause of the fall to assist in implementing appropriate, timely interventions for 1 of 2 residents (R24) reviewed for falls. This practice resulted in actual harm to R24. In addition, the facility failed to ensure a Wanderguard (personal tracking alarm) was functional for 1 of 1 residents (R75) reviewed for wandering and ensure smoking aprons were worn as assessed for 2 of 2 residents (R75, R27) reviewed for smoking. Findings include: R24's annual Minimum Data Set (MDS) dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfers and ambulation. The MDS also identified diagnoses of hypertension, arthritis, dementia and anxiety. The MDS indicated R24 had two or more falls without injury since the last assessment dated 1/25/17. R24's fall Care Area Assessment (CAA) dated 4/28/17, identified R24 was at risk for falls due to	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
THE ESTATES AT DELANO LLC 433 COUNTY ROAD 30 DELANO, MN 55328 CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG	00933		00933	B. WING		06/02/2017	
(X4) ID PREFIX TO BLANO, MN 55328 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 23 review, the facility failed to follow existing fall interventions and comprehensively assess falls to identify the root cause of the fall to assist in implementing appropriate, timely interventions for 1 of 2 residents (R24) reviewed for falls. This practice resulted in actual harm to R24. In addition, the facility failed to ensure a Wanderguard (personal tracking alarm) was functional for 1 of 1 residents (R75) reviewed for wandering and ensure smoking aprons were worn as assessed for 2 of 2 residents (R75, R27) reviewed for smoking. Findings include: R24's annual Minimum Data Set (MDS) dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfers and ambulation. The MDS also identified diagnoses of hypertension, arthritis, dementia and anxiety. The MDS indicated R24 had two or more falls without injury since the last assessment dated 1/25/17. R24's fall Care Area Assessment (CAA) dated 4/28/17, identified R24 was at risk for falls due to	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 23 review, the facility failed to follow existing fall interventions and comprehensively assess falls to identify the root cause of the fall to assist in implementing appropriate, timely interventions for 1 of 2 residents (R24) reviewed for falls. This practice resulted in actual harm to R24. In addition, the facility failed to ensure a Wanderguard (personal tracking alarm) was functional for 1 of 1 residents (R75) reviewed for wandering and ensure smoking aprons were worn as assessed for 2 of 2 residents (R75, R27) reviewed for smoking. Findings include: R24's annual Minimum Data Set (MDS) dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfers and ambulation. The MDS also identified diagnoses of hypertension, arthritis, dementia and anxiety. The MDS indicated R24 had two or more falls without injury since the last assessment dated 1/25/17. R24's fall Care Area Assessment (CAA) dated 4/28/17, identified R24 was at risk for falls due to	THE EST	TATES AT DELANO LL	C		0		
review, the facility failed to follow existing fall interventions and comprehensively assess falls to identify the root cause of the fall to assist in implementing appropriate, timely interventions for 1 of 2 residents (R24) reviewed for falls. This practice resulted in actual harm to R24. In addition, the facilty failed to ensure a Wanderguard (personal tracking alarm) was functional for 1 of 1 residents (R75) reviewed for wandering and ensure smoking aprons were worn as assessed for 2 of 2 residents (R75, R27) reviewed for smoking. Findings include: R24's annual Minimum Data Set (MDS) dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfers and ambulation. The MDS also identified diagnoses of hypertension, arthritis, dementia and anxiety. The MDS indicated R24 had two or more falls without injury since the last assessment dated 1/25/17. R24's fall Care Area Assessment (CAA) dated 4/28/17, identified R24 was at risk for falls due to	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfer. The CAA also indicated R24 had falls since the last assessment and was also taking antianxiety medication. The CAA identified R24 was at risk for further falls and fall related injuries. A care plan was developed to avoid complications and minimize risks. R24's Fall Risk Evaluation dated 4/18/17, indicated R24 had multiple falls over the last 6	2 830	review, the facility finterventions and contidentify the root causimplementing appropriate 1 of 2 residents (R2 practice resulted in addition, the facility Wanderguard (persunctional for 1 of 1 wandering and ensure worn as assessed for reviewed for smoking findings include: R24's annual Minimel 4/19/17, indicated Findings include: R24's annual Minimel 4/19/17, indicated Finding include: R24's fall Care Area and ambulation. The Minger falls without in assessment dated R24's fall Care Area 4/28/17, identified Finding unsteady and moving from seated turning around and while walking, moving surface to surface to surface to indicated R24 had and was also taking CAA identified R24 fall related injuries. avoid complications R24's Fall Risk Evaluations.	ailed to follow existing fall omprehensively assess falls to use of the fall to assist in opriate, timely interventions for 24) reviewed for falls. This actual harm to R24. In failed to ensure a sonal tracking alarm) was residents (R75) reviewed for ure smoking aprons were for 2 of 2 residents (R75, R27) ng. The magnetic of the fall of the	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00933		B. WING		06/0	2/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT DELANO LL	C	NTY ROAD 30 , MN 55328	0		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
for falls. R24's care plan reversed had a potential for fincluded the use of 6/14, which resulted hemorrhage, result mobility/cognition, in higher risk for falls. had fallen several relateventions included mat on floor bedside bed and chair; ensuranticipate needs, polight within reach wentive environment free of weekly, and monitod R24's undated Growindicated safety into bed, floor mat and select side with a skin and a pink area to form indicated the select side with a skin and a pink area to form. Incident a.m. identified a positioned and the form. The Fa 3/3/17, at 3:20 a.m. at 2:45 a.m., however toileted, positioned, on the form. The Fannick and the form is the form. The Fannick and the form is the form in the form. The Fannick and the form is the form is the form is the form. The Fannick and the form is	rised on 3/8/17, identified R24 falls/ accidents. Risk factors medications, pain, a fall in d in an intracranial ing in impaired mpulsivity, and placing him at The care plan identified R24 more times since the initial fall. ded: bed in low position, fall le, mobility monitors on R24's ure they are on and working, rovide rest periods, keep call then in room, keep f clutter, monitor vital signs or for medication side effects.	2 830	DELIGITIENCI)		

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fold the scale when not in use. The rest of the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00933		B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	ITY ROAD 30 MN 55328	0		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 25	2 830			
	folding the scale wa	hough an intervention of as implemented, it did not ety or initiate an intervention xiety.				
	indicated R24 had a was found lying on between his night s received an injury of elbow skin tear med 0.5 cm. The right scm x 0.5 cm. The findicated R24 had a predisposing physic and ambulating/tranimproper/no footwewere identified. Imaid to the skin tears continued restless wheelchair. The Indated 5/5/17, identias "unknown." Interemove the over the night stand away frointerventions were sinjury, it did not add	e dated 5/4/17, at 2:00 a.m. a fall from from his bed and his right side on his "floor mat" tand and his bed. R24 of two skin tears. The right asured 2 centimeters (cm) x shoulder skin tear measured 3 fall investigation dated 5/3/17, no environmental factors, no plogical factors, had dementia, asferring without assist with ear. No predisposing factors mediate action taken was first and due to the resident's less, staff assisted him to his cident Review and Analysis fied potential causative factors rventions added were to be bed table, and move the om the bed. Although added to reduce the chance of tress a potential cause or an emize the risk of a subsequent				
	indicated R24's bed at 1:20 a.m. Staff f stomach "on the flo from a head laceral paramedics at 1:55 investigation. The li dated 5/15/17, iden factors as resident	e dated 5/11/17, at 3:13 a.m. d alarm went off in R24's room ound R24 lying on his or" in a pool of blood, coming tion. R24 left with the a.m. There was no fall neident Review and Analysis tified potential causative attempting to get out of bed, but suspect toileting needs.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			- WING			
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	NTY ROAD 3 MN 55328	U		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Intervention added rounds. R24's 5/11/discharge report indischarge rep	was to toilet on first night '17, emergency room dicated he received seven acceration from his fall. This fall all on 5/3/17, however; the ot indicate R24 was found on fall mat was in place at the re was no investigation mine the details of the fall and risk of further falls. on 5/30/17, at 2:34 p.m. R24 wheelchair wearing yellow did not have a strap behind on 5/31/17, at 7:37 p.m. R24 thout a fall mat on the floor by of faded yellow Crocs sandals the bottom of the sandals were little tread remaining on the	2 830			

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		00933	B. WING		06/02/2017	
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THE EST	TATES AT DELANO LL	С	ITY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	830 Continued From page 27		2 830			
	worn. TMA-A furthe	ndals and stated they were er stated, "I don't like them mbest thing for an elderly man				
	practical nurse (LPI initiated right away source" of the fall. falls committee to he reviewed at stand uperiday. LPN-A state socks on or the yell observed the Crocs no tread on the bott need to take those	6/1/17, at 1:12 p.m. licensed N)-A stated an intervention is following a fall "if we know the LPN-A stated there was not a ter knowledge, but falls were p meetings Monday through ed R24 usually had gripper ow Crocs sandals. LPN-A is sandals and stated there was som of the sandals, "I think we away, I'm going to take those emoved the sandals from				
	During observation on 6/1/17, at 2:52 p.m. the scale at the end of the South hallway was unfolded and not in use.					
	stated interventions into place following there were too man there heads and no it. LPN-C stated sh supervisors, but the stated there were s don't know what the stated the facility dicause of a fall or in interventions to pre R24 can walk with a she over hears the one offered to take	6/2/17, at 8:10 a.m. LPN-C are not routinely being put a fall. LPN-C further stated y people falling and hitting one is doing anything about the communicated this to the ey just "blow it off." LPN-C to many new nurses here that ey are doing. LPN-C further donot try to determine the explement appropriate event future falls. LPN-C stated assistance and many times staff say just sit down, and no him for a walk. LPN-C stated do to be taken more seriously."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF PROVIDE		433 COUN	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES A	AT DELANO LL	C	MN 55328	•		
	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
During scale unfold proper gripped gripped gripped gripped buring regists stated identification into plant the far 5/3/17 had becomp comported for time. During stated supped also set the time buring direction had comported falls the proper form in urse interves falls a imme	at the end of ded and was relating himself in er socks up are grinterview on ered nurse (Rd on 5/3/17, a fied following lace did not pill on 5/11/17, and was not een initiated. The rehensive fall leted with the er stated that a supposed to meeting on busing gling with control of the scale at some the scale at several to be followed and the scale at several entities a few mention into plant on the plant of the plant on the plant of the plant on the plant on the plant of the plant on the plant of the plant on the plant of	on 6/2/17, at 8:31 a.m. the the South Hall was again not in use. R24 was self in his wheelchair wearing and down the South Hall. 6/2/17, at 9:26 a.m. RN)-A reviewed R24's falls and causative factor was not the fall and the intervention put revent future falls. RN-A stated was similar to the fall on the sure if a bladder assessment RN-A further stated a assessment was only MDS assessments. RN-A an interdisciplinary team (IDT) in the every morning for stand and interdisciplinary team (IDT) in the end of the South Hall was ded up when not in use. NA-D after the down position most of a 6/2/17, at 10:33 a.m. the (DON) stated the fall process switching management anonths ago. When a resident upposed to document the fall in and fill out an investigation ement. The DON stated the ace to try and prevent further assessing and treating the DON stated the IDT review and had not consistently been	2 830			

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	NTY ROAD 30 MN 55328	J		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From pa	ge 29	2 830			
	stated she complete Analysis following the stated R24's fall on Wednesday and the incident until 5/5/17 potential cause was thought it could be trazodone (antidepr DON stated after lof fall investigation was fall on 5/11/17. DO progress note it was on the floor at the tid DON stated she experies followed. DON stated she experies followed. DON stated toileted on the first complete a bladder toileting times was a DON stated R24's sevaluated for safety been removed on 6 contacted. DON further was not always look cause of the fall toplace. DON further effectively evaluated complete investigat was aware of incomor of interventions follof facility and she development in the opportunity complete document immediately following A facility policy Falls.	following business day. DON teed the Incident Review and the IDT review of the fall. DON in 5/3/17, happened on a sel IDT did not review the review the respective to not sleeping and ressant) was started on 5/9/17. Tooking in risk management, a selection of the fall on 5/9/17. Tooking in risk management, a respective to the fall on 5/11/17. Tooking the fall on 5/11/17, and fall interventions to stated following the fall on an intervention for R24 to be night shift rounds, but did not reassessment to identify if a potential cause of the fall. Shoes had never been and stated the shoes had 5/1/17, and family was urther stated when reviewing retings, the fall investigation ked at to try and determine the put effective interventions into restated falls can not be add without looking at a tion. DON further stated she inplete documentation and lack owing a fall for resident's at the reloped a plan in quality a situation, however; had not a to train the nurses on the station and lack of interventions ing a fall. s-Clinical Protocol dated 5/13, or an individual who has fallen,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	C 433 COUN	DRESS, CITY, S NTY ROAD 30 MN 55328	STATE, ZIP CODE 0			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	staff will attempt to 24 hours of the fall be readily identified various relevant into assessment of the until falling reduces identified for its con individual continues without waiting for a LACK OF WANDER R75's admission M 2/21/17, identified F impairment and wa R75 at risk of gettin place. R75's care plan data trisk for elopemer leaving the facility awere to have no incremain safe during Further, the care pl "Wanderguard place record revealed no 2/17. R75's Treatment Adwere reviewed from lacked any order or R75's Wanderguard until 5/31/17, when to, "Check function "Check wandergua and skin concerns."	define possible causes within If underlying causes cannot , or corrected, staff will try erventions, based on nature or category of falling, or stops or until a reason is itinuation (for example, if the sto try and get up and walk assistance)." RGUARD MONITORING: Inimum Data Set (MDS) dated R75 had moderate cognitive ndering behavior that placed ag to a potentially dangerous and wandering. R75's goals sidence of elopement and placement at the facility. In an indicated an intervention of, ed." Review of the medical elopement attempts since and intervention of the medical elopement attempts since and complete the comp	2 830				
	was outside on the	on 5/31/17, at 1:33 p.m. R75 smoking patio having a not have a Wanderguard on.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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THE EST	TATES AT DELANO LI	C	ITY ROAD 30 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From page 31		2 830			
	lying in his bed on clothed. He was whave a Wandergual located on his beds on the Wandergual During interview or stated he used to wrist, but the band about three weeks staff the band was but no one had fixe Wanderguard. R7sthe Wanderguard i	n 5/31/17, at 7:18 p.m. R75 wear a Wanderguard on his on the Wanderguard broke ago. R75 stated he told the broken on the Wanderguard, ed it or given him a new 5 stated sometimes he kept n his pants pocket and				
	When interviewed on 5/31/17, at 7:26 p.m. TMA-A stated R75 wore a Wanderguard and it would sound an alarm if he attempted to go outside. At 7:30 p.m. surveyor and TMA-A went to R75's room together and R75's Wanderguard was sitting on his bedside table. The band on the Wanderguard was broken. TMA-A looked at R75's Wanderguard on his bedside table and stated R75 should have it attached to his body and not sitting on the bedside table. During interview on 5/31/17, at 7:33 p.m. the DON stated she would go and look at R75's Wanderguard. Together, the surveyor and the DON looked at R75's Wanderguard that was broken on his bedside table. The DON took the Wanderguard, replaced the band and placed the Wanderguard on R75's right wrist. The DON stated it was on the TAR for staff to check placement of R75's Wanderguard every shift.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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	OLIMANA DV. OTA		MN 55328	DDOV/IDEDIO DI ANI OE CODDI	FOTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 32	2 830			
	stated R75 was an Wanderguard locat stated she was not placement or check Wanderguard was not know how to ch working, adding; "T During interview on stated R75 did not stated staff do not of wears a Wanderguaware of which resident controls."	elopement risk and wore a ed on his wheelchair. She aware if any staff checked the ted to see if R75's working. NA-K stated she did eck if a Wanderguard was hat is a good question." 6/1/17, at 8:04 a.m. NA-J wear a Wanderguard. NA-J check to see if a resident ard, adding staff was just dents wandered.				
	stated R75 wore a land it was checked was on and the nur resident's medication LPN-A stated the nifunction of the Wan order for checking I got entered on 5/31 one was checking the R75's Wanderguard was and entered was checked was and entered was checked was che	on 6/1/17, at 8:35 a.m. LPN-A Wanderguard on his left ankle every shift to make sure it ses documented in the on administration record. If the shift staff checked the derguard. LPN-A stated the R75's Wanderguard had just /17, and prior to 5/31/17, no he placement or function of d. When informed the on his right wrist, LPN-A aware of that and thought it ankle.				
	policy dated 8/2013 each transmitter in nurse of each resid unit. The alarm and by taking the reside and document appropriate and the second of the second o	Wandering Monitor System is, indicated on a weekly basis use would be tested by the ent who wore the transmitter distransmitter would be tested ent through the alarmed doors copriately in the resident's e policy also indicated the would be checked on a par and tear, and replaced as could be documented in the				

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		00933	B. WING		06/02/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	ITY ROAD 3	0		
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	MN 55328	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From page 33		2 830			
	resident's medical r	ecord.				
	LACK OF SAFETY INTERVENTIONS WITH SMOKING:					
	R75's admission Minimum Data Set (MDS) dated 2/21/17, identified R75 had moderate cognitive impairment, required limited assistance with activities of daily living (ADLs) and did not use any tobacco products. R75's undated Diagnosis Report identified R75 had a diagnosis on admission to the facility of, "Tobacco Use." R75's care plan dated 3/22/17, identified a focus area of, "Resident currently smokes at this facility," and listed a goal for R75 of, "Resident will smoke safely." The care plan listed					
		included, "Independent with ation" and "Smoking apron per				
	indicated R75 had of deficit and smoked evaluation identified equipment which in The smoking evaluation indication interventions indication himself outside, lighter properly dispose of accepting of wearing accepting of facility policy and times we	aluation dated 3/10/17, cognitive loss and a visual two to five times per day. The d R75 required adaptive cluded a "Smoking apron." ation summary and ted R75 was able to safely get at his own cigarette, and his cigarette. R75 was ag a smoking apron and smoking times. The smoking ere also reviewed with R75 and and they agreed to them.				
	stated he went outs and there were spe by the nurse's static	5/30/17, at 1:32 p.m. R75 side four times a day to smoke cific times of the day posted on of when he could go out to ated the staff gave him his				

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		00933	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER	C 433 COU	DDRESS, CITY, ST NTY ROAD 30 , MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	cigarettes when it went outside to the wheelchair. He had but the smoking ap apron remained folche was outside smoking cigarette by him extinguish his cigar However, the entire safety apron remain was no staff supervent when observed on sitting by the nurse' cigarettes. Staff halighter, and a smok himself outside to the smoking apron remained to the smoking apron inside the facility. On 5/31/17, at 1:33 he wore the smoking apron inside the facility. On 5/31/17, at 7:23 stated R75 was a semoke. She furthe smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not believe R75 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75 wind During interview on the smoking apron whe did not page 20 outside with R75	vas time to go out to smoke. on 5/30/17, at 1:32 p.m. R75 smoking patio in his d a smoking apron on his lap, ron was not opened. The ded on his lap the entire time beking. R75 was able to light iself, ash safely, and ette without difficulty. It time R75 was smoking, the ned folded on his lap. There rising R75 while he smoked. 5/31/17, at 1:28 p.m. R75 was station requesting his inded him two cigarettes, his ing apron. R75 propelled he smoking patio. The rained folded on his lap. At rained sometimes he on and told R75 he must have butside smoking. NA-L placed on R75 and then went back a p.m. R75 stated sometimes and apron and sometimes he on how he felt. R75 stated he a the smoking apron on his lap. p.m. nursing assistant (NA)-H moker and he went outside to r stated R75 had to wear a en he was smoking and she needed a staff member to be				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/02/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE ES	TATES AT DELANO LL	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	smoker. She further were evaluated to be resident was able to safely, the resident TMA-A also stated to wear a smoking. When interviewed of director of nursing (smoker and R75 ware apron when he were further stated R75 ware apron on his lap whif R75's smoking as supposed to be were "should have be be "should have be be "should have be be "should have be be be used and body and LPN-A also added lap. "This could possed to be were and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A also added lap. "This could possed to be well and body and LPN-A the smoking apron chest and body and LPN-A the smoking apron	er stated residents that smoke be safe smoking and if the be light, ash, and extinguish was allowed to smoke. If or extra safety, residents had apron. on 5/31/17, at 7:44 p.m. the (DON) stated R75 was a last asked to wear a smoking at outside to smoke. The DON usually just set the smoking ten he smoked. DON added, assessment indicated R75 was aring a smoking apron, then	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	02/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	NTY ROAD 30 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	interventions include equipment," with a warms apron [de to prevent burns from R27's care plan date be currently smoking with a goal listed of Further, the care plaincluding, "Use walks smoke," and, "Smo During observation came to the nursing folded up gray color three single cigarett nurse (LPN)-E. R27 walker and sat in a placed the folded up outside and procee and smoke them. Fand had no burn ho stated the staff was the provided smoking questioned it." During interview on assistant (NA)-D stamp interview on assistant (NA)-D s	ge 36 ing need for adaptive written, "X" placed next to, evice covering skin and clothes om dropped ashes]." eed 4/20/17, identified R27 to ge while at the nursing home, "Resident will smoke safely." an listed interventions ker while going outside to king apron per evaluation." on 5/30/17, at 1:34 p.m. R27 ge station and was provided a red smoking apron, lighter and tes from licensed practical ambulated outside using his chair on the patio. R27 pe smoking apron on the table ded to light his cigarette(s) R27 did not drop any ashes bles visible in his clothing. R27 aware he was not wearing apron but had, "never as during her shift at the etimes." NA-D stated R27 pron outside with him and staff with it if he wanted it as, "That's tated use of the smoking recommended," though to urns. NA-D stated she had it to monitor R27 when he is	2 830			
		on 6/1/17, at 12:16 p.m. the f nursing (ADON) stated R27				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED	
		00933	B. WING		06/0	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	С	ITY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	should be using the his most recent evaluated residents and/or assistance we evaluated for need flame retardant appropriate for the educate all staff. The monitoring systems compliance and repassurance committer recommendations.	e smoking apron as directed by illuation. Smoking Policy dated 6/14, that required supervision with smoking would be of adaptive equipment (i.e., on, cigarette extension int who did not comply with se independent smoking evaluated and determined to idependently. CHOD OF CORRECTION: The im (IDT) could develop safety the risk for resident individually assessed to be reisdent. The IDT could ite IDT could develop to ensure ongoing fort those results to the quality	2 830			
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			7/17/17
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so	o enters the nursing home ores does not develop ess the individual's clinical				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/02/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		-
THE ES	TATES AT DELANO LI	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	condition demonstrauthenticates, that B. a resident was receives necessar promote healing,	rates, and a physician they were unavoidable; and who has pressure sores by treatment and services to revent infection, and prevent veloping. The provided in	2 900	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
	PROVIDER OR SUPPLIER	C 433 COUI	DRESS, CITY, S NTY ROAD 3 MN 55328	STATE, ZIP CODE 0		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	front, left lower legal lower leg rear, right listed twice, right ar ankle outer. The as type of skin impairm measurements. The any area of concern R18's Tissue Tolera 3/16/17, indicated a of every two hours. include a sitting recrepositioning. R18's Braden Scale pressure ulcer risk) completed, the asserties and for mobiling assist with transfers turn and reposition two hours and as not R18's admission Mid 3/22/17, did not ide The MDS indicated assistance with bed MDS identified R18 pressure ulcers. The relieving intervention device in bed and a the chair. The MDS reposition schedule	front, right lower leg rear, left ankle inner, left ankle inner lakle outer listed twice, and left sessment did not identify the nent and lacked any e assessment did not address in to either of R18's heels. Ince Observation dated a lying repositioning schedule The observation did not ommendation for e (assessment to identify dated 3/20/17, was not essment was blank. al Care Plan (temporary care rity did not include imize pressure ulcer risk. The ty/safety directed staff to s, assist with bed mobility, and or reminders to offload every	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
	00933	B. WING		06/02/2017	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	2/2017
	433 COUN	ITY ROAD 3			
THE ESTATES AT DELANO LLO	C	MN 55328			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
(CAA) dated 3/28/17 develop pressure uldextensive assistance frequent bladder and admitted to the facilistaples to the right has pressure ulcers and The CAA directed stakin assessment and Interventions in place reduction mattress a was to assist with turn R18's Skin Evaluation Stage 1 pressure ulcanon-blanchable reduction mattress a was to assist with turn R18's Skin Evaluation Stage 1 pressure ulcanon-blanchable reduction mattress a was to assist with turn R18's Skin Evaluation Stage 1 pressure ulcanon-blanchable reduction usually over a bony measuring 2 centime identified the area as also identified a Stage thickness loss of details of the propen/ruptured blister cm x 1 cm x 0.3 cm. include any further dulcers, interventions treatment initiated. The Evaluation was com 3/22/17, as the treat it was initialed as con R18's progress note discharge on 3/31/17 the physician was not two Stage 2 pressure.	r Care Area Assessment 7, indicated R18 was at risk to cers related to a need for e with bed mobility and d bowel incontinence. R18 ty with surgical incisions with hip. R18 had no history of no current pressure ulcers. aff to refer to the admission d weekly skin assessment. e included a pressure and wheelchair cushion. Staff rning and repositioning. on dated 3/29/17, indicated a cer (intact skin with ness of a localized area prominence) on the right heel eters (cm) x 2 cm. Staff s a blister. The assessment ge 2 pressure ulcer (partial rmis presenting as a shallow d-pink wound bed without resent as an intact or r) to the left heel measuring 2 The assessment did not description of the pressure , physician notification or There was no evidence a Skin pleted the previous week on ment sheet directed, although	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00022	B. WING		00/00/0047	
		00933	l .		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT DELANO LI	C	NTY ROAD 3 MN 55328	U		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	indicate the physici Stage 2 pressure u order to discharge not include orders to the control of	r Sheet dated 3/29/17, did not an was notified of the two lcers. The order included an home with home care, but did to treat pressure ulcers. In p.m. the licensed dietician had completed R18's ment on 3/23/17, and reviewed harge summary, progress assessments, which did not re ulcers. LD-A stated she had resulted she was not notified of and would expect to be, so did be re-evaluated and intions implemented to 1.6/2/17, at 8:23 a.m. licensed N)-C stated a full skin equired to be completed within ion and then weekly after that, in assessment form was did it was not acceptable to just atment sheet. LPN-C stated the was a reminder to complete PN-C further stated the Braden completed by the registered MDS assessment. LPN-C stated at massessment. LPN-C stated at was a reminder to complete possure area was identified, a finitiated, along with notifying y and director of nursing. Our nurse admitting the insible to fill out all areas of the in.	2 900			
		a.m. registered nurse (RN)-A care plan and stated the skin				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00933	B. WING		06/0	2/2017
NAME OF PR	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE ESTA	TES AT DELANO LL	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
r t a correct the first th	then pulled up the 3 and stated it was bland stated it was bland stated. RN-A stresponsible for comble temporary care has time she will as RN-A further stated were to be docume electronic medical rathe 3/29/17, skin as indicated R18 develucers on her heels should have been up an agers to ensure and the cause of the investigated. RN-A inspect R18's skin was relied on nursing doner assessment. On 6/2/17, at 9:41 told R18 had development and should responsible for complete a full skin the findings on a for MDS nurse should were not completed assessments and should responsible for complete a full skin the findings on a for MDS nurse should were not complete cassessments and should responsible for complete a full skin the findings on a for MDS nurse should were not complete cassessments and should responsible for complete a full skin the findings on a for MDS nurse should were not complete cassessments and should responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete cassessments and should responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete of the findings on a formal responsible for complete of the findings of the findi	ye any interventions. RN-A 8/20/17, Braden assessment ank and had not been tated the floor nurses were apleting the Braden along with plan. RN-A stated when she sist them with assessments. The weekly skin assessments and on the form in the record (EMR). RN-A reviewed assessment and stated it loped two Stage 2 pressure. RN-A stated the physician updated along with the retreatments were appropriate to the result of the r	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/02/2017	
NAME OF PROV	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES	S AT DELANO LL	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
pre exp ass care Sta "coo On was p.m did the dev adm the pre whe ord The dire ord par fam and doo woo aud eva their mei 12. Cor R44 4/20 imp acti	pectations were to be sements along the plans. DON stage 2 pressures incern." 6/2/17, at 11:31 as left for R18's particular and she reloped two Stage facility and she reloped two Stage facility and she reloped two Stage facility to impler source ulcer and the provide application of the pro	e DON further stated her timely and complete with completed temporary ated R18 developing two ulcers after admission was a a.m. a telephone message hysician. On 6/5/17, at 1:38, R18's physician stated she are ulcers upon admission to was not made aware R18 had ge 2 pressure ulcers after visician stated she expected ment interventions to prevent would expect to be notified veloped pressure ulcers in propriate treatment. Wound Process Checklist Notify MD/Treatment as family and/or responsible completed with resident and party including review of risks art weekly wound and the state of	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/	02/2017
	PROVIDER OR SUPPLIER FATES AT DELANO LL	C 433 COUN	DRESS, CITY, S NTY ROAD 3 MN 55328	STATE, ZIP CODE 0		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 900	ulcer development. R44's care plan data a pressure ulcer du incontinence and liridentified R44 had a ulcer on his buttock complete, "Weekly "Conduct weekly sk" During observation licensed practical n in R44's room to ch dressing. R44 was positioned on his lefoam dressing from visible pressure ulchad no visible drain ulcer appeared to b (centimeters) by 1 cany odor. LPN-C simeasure the ulcer w"That's only schedus sprayed R44's wous cleanser; however, procedure and the cleanser; however, procedure and the cleanser; however, when interviewed cleanser ulcer. When interviewed cleanser ulcer if diradministration reconstated R44's pressure ulcer if diradministration reconstated R44's pressure ulcer if diradministration reconstated R44's pressure ulcer is diradministration reconstant.	red 5/8/17, identified R44 had e to bowel and bladder mited mobility. The care plan a current stage III pressure and directed staff to wound assessment," and,	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LI	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	dated 4/25/17, to 5 "Complete Weekly Health Managemer Evaluation] under f This was scheduled basis on 4/26/17, 5/24/17 and 5/31/1 entry was recorded on 5/10/17, the entrefused." Further, recorded as, "Othe R44's MHM Weekl 4/30/17, identified If ulcer on his coccyx 2 cm (centimeters; 0.3 cm (depth) in stissue (red tissue in wound bed. The upresent. Further, tisection labeled, "Sichanges. Continue weeks." R44's MHM Weekl 5/1/17, (one day affidentified R44 had his coccyx. The ulcomplete R44 had his cocc	dministration Record (TAR) /30/17, directed staff, wound evaluation [Monarch int (MHM) Weekly Wound orms tab for coccyx wound." d to be completed on a weekly /3/17, 5/10/17, 5/17/17, 7. However, on 5/3/17, the l as, "Absent from home," and ry was recorded as, "Drug on 5/17/17, the entry was r / See Nurses Notes." y Wound Evaluation dated R44 had a stage III pressure i. The ulcer was measured as length) X (by) 0.1 cm (width) X ize with 100% granulation indicative of healing) in the licer had no drainage or odor the evaluation included a fummary," with, "No new is to go to wound clinic every 2 y Wound Evaluation dated ter previous evaluation), a stage III pressure ulcer on cer was measured as 2 cm width) X 0.3 cm (depth) in size tion tissue (red tissue indicative found bed. The ulcer was scant" drainage now present int. Further, the evaluation ection labeled, "Summary," cable] - Does go to wound MHM Weekly Wound /19/17, (18 days after last	2 900			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		2222	B. WING	R WING		0/004=
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE ESTATES AT DELANOTIC			ITY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	evaluation), identification in the ulcer was meat cm (width) X 0.4 cm description of the work with no amount of conselected, along with being selected. The "Wound Edges," who "Intact." Further, the section labeled, "Sur was left blank. R44's most recent I Evaluation dated 5/evaluation), identification pressure ulcer on homeasured as 1.8 cm 0.4 cm (depth) in si and 25% slough (depth) in si and 25% slough (depth) in the identified to have not be further, the section identified, "No chank wound has had soon a routine basis to monitoring for healing the identified with the identified with the section identified in the section identified in the section identified with t	ed R44 now had an, wn wound but unable to bed]" ulcer on his coccyx. sured as 2.3 cm (length) X 0.3 in (depth) in size. A, "Further ound," section was left blank or type of drainage being in no dictation of any odor e only selected option was, nich were identified as, in e evaluation again included a ammary," however, this section with the work of the	2 900			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/02/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	characteristics of the visit on 5/17/17, on to be, "SI [slightly] led dressing change or when interviewed of director of nursing of were responsible to R44's pressure ulce MHM Weekly Wour electronic medical recoulcer had not been have been, "for conthe wound is healin [was] still effective." A facility Weekly Ch Documentation polipurpose which included in the wound is not been have been, "for conthe wound is healin [was] still effective." A facility Weekly Ch Documentation polipurpose which included in the wound is not been have been, "for conthe wound is healin [was] still effective." SUGGESTED MET director of nursing of develop systems to ulcer development infection when preson designee could of the DON or design systems to ensure report those results committee for ongo	y measurements or ne wound. The most recent ly identified the pressure ulcer less deep," and provided ders. on 6/2/17, at 11:35 a.m. the (DON) stated the floor nurses of measure and document ler on a weekly basis using the land Evaluation form(s) in the record. The DON reviewed rowed and stated his pressure tracked weekly, but should latinued monitoring to ensure g," and R44's, "Treatment of the latinustic stated several ing the stage of the pressure of the ulcer, and if undermining present. THOD OF CORRECTION: The (DON) or designee could designed minimize the risk for pressure and rapid healing without source ulcers develop. The DON reducate all appropriate staff, nee could develop monitoring ongoing compliance and it to the quality assurance	2 900			
	(21) days.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0)2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21525	A nursing home muservices of a pharm Board of Pharmacy A. provides corprovision of pharmathome; B. establishes and disposition of a detail to enable and C. determines accurately maintain controlled drugs is a controlled drugs in controlled drugs is a controlled drugs in controlled drugs is a controlled drugs in controlled drugs is a controlled drugs in controlled drugs	a system of records of receipt ll controlled drugs in sufficient accurate reconciliation; and that drug records are ed and that an account of all	21525	Corrected		7/17/17

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COIVIP	LETED
		00933	B. WING		06/02/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		433 COUN	NTY ROAD 3			
THE EST	TATES AT DELANO LL	C	MN 55328	•		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				22.16.2.10		
21525	Continued From pa	ge 49	21525			
	"Yes." adding. "But	only if she consents to daily				
		o see me within 2 weeks."				
	weights and plans to see me within 2 weeks.					
		of medication administration				
	T	p.m. licensed practical nurse				
		R26's medications at a mobile				
		LPN-B provided a package to				
	the surveyor of the medications to be administered which included a single Lasix 40 mg					
		e was dispensed from an				
	automated machine and did not include					
	administration instr	uctions. LPN-B reviewed				
		dministration Record (MAR)				
		rosemide Tablet 20 mg Give 2				
		outh two times a day [for a				
		as directed by the fax dated 3 administered the single 40				
	mg tablet of Lasix to	•				
	9 10.0.01 0. 200.01 1	- 10.				
	R26's medical reco	rd was reviewed for current				
		R26's physician visit note				
		fied R26 had been seen by				
		ncluded a section labeled,				
		lication List," which listed iding, "Furosemide [Lasix] 20				
		ections, "Take 3 tablets [60 mg]				
		y." This document was signed				
		ing home staff and dated				
	5/11/17.					
	ا د د ا د د د الله المالية					
		equent physician visit note tified R26 had been seen in				
	the emergency roo					
		Soft tissue complaint." The				
		n labeled, "Your Medications,"				
	with directions to, "	Take these medicines as				
	prescribed by your	regular doctor. These				
		reviewed at the hospital."				
		ed several medication orders				
	including, "Furosem	nide 20 mg tablet," and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 2313	
THE ES	TATES AT DELANO LI	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21525	directed, "Take 3 tamorning," for alcohascites (fluid build or R26's nursing progidentified R26 returned partment with, "rot identify if the dibeen clarified. When interviewed assistant director or reviewed R26's harbeen getting Lasix 80 mg a day) since on 4/27/17, howevetimes, both in the ordepartment since the visit was Lasix 20 mg a day being and spoke with R20 mg a day being and 50 mg a day being and 50 mg a day being and 50 mg a day being and 60 mg a day being and 60 mg a day being and 50 mg a d	ablets [60 mg] by mouth every olic cirrhosis of the liver with up in the abdomen). Tess note dated 5/18/17, ned from the emergency to new orders." The note did fference in Lasix dosing had The following (ADON) stated she and chart and MAR. R26 had and the faxed order was signed er, had been seen several linic and emergency nen. The order listed at each and three times a day (a total of DN stated she called the clinic of sphysician who stated the 80 ministered was correct, not the identified on the visit note(s). The order listed the orders receiving the correct dose of added the discrepancy had everal" different staff members eviewed the paperwork. The order listed the discrepancy not being the a medication policy was	21525			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/02/2017	
	PROVIDER OR SUPPLIER	C 433 COUN	DRESS, CITY, SITY ROAD 3	STATE, ZIP CODE 0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21525	ER trips, and consube educated on the designee could devensure ongoing corresults to the quality further recommend	ults. All appropriate staff could se systems. The DON or elop monitoring systems to appliance and report those y assurance committee for	21525			
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.		21610			7/17/17
	by: Based on observati review, the facility for procedures to ensure substances to reductive facility failed to import apid detection of profit 2 medication car. This had potential to review facility failed to import apid detection of profit 2 medication car.	on, interview and document ailed to implement policies and re safe storage of controlled ce the risk of potential residents (R39, R5) observed medications. Further, the lement practices to ensure otential narcotic diversion for 2 ts reviewed during the survey. To affect 13 of 13 residents nt orders for narcotic facility.		Corrected		
	UNSECURED MED	DICATIONS:				
	A facility Controlled	Substance Storage policy				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71101011	or contraction	ibertii io/trieit iteiniberti	A. BUILDING:			
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE E01	-ATEO AT DEL ANO LL	433 COUN	NTY ROAD 3	0		
THE EST	THE ESTATES AT DELANO LLC DELANO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21610	Continued From page 52		21610			
	dated 6/15, identified controlled substant handling, storage, of the facility in accordance other applicable law policy directed, "Somedications and ot abuse or diversion affixed, double-lock from all other media regulation."	ed medications classified as sees were, "subject to special disposal and record-keeping in dance with federal, state and vs and regulations." The hedule II - V [two through five] her medications subject to are stored in a permanently sed compartment separate cations or per state				
	was reviewed with I (LPN)-A. The room and a small Danby the floor underneath the refrigerator was unlocked gold color the hinge. The padl refrigerator without refrigerator content two opened bottles medication and classinside - one each for remaining medication.	a.m. the medication room licensed practical nurse in was locked by physical key Designer refrigerator was on the counter. On the side of a hinge device and a red pad lock inserted through lock was removed from the having to use a key and the s reviewed. Contents included of lorazepam (an anti-anxiety size IV controlled substance) or R39 and R5. The amount of on inside the bottles was ound register count and found				
	observation, LPN-A have been kept loc [lorazepam] in there	mmediately following the a stated the refrigerator should ked, "because there's Ativan e." LPN-A stated lorazepam be a narcotic medication and backed at all times.				
	director of nursing (stored in the refrige	6/2/17, at 11:41 a.m. the (DON) stated lorazepam erator, "should be double to prevent potential diversion.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT DELANO LL	C	ITY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21610	10 Continued From page 53		21610			
	When interviewed of consulting pharmacy should have been of facility policy, "It should have been of facility policy, and the several various narked to the cart as several various narked narcotics we shift," and the councompleted on a flow the medication cart to the surveyor which shift Controlled Sulforth to the surveyor which shift nurses to record including the date, seach shift nurse to and departure. A to required to satisfy the laid out on the flows were left blank and May 1 - One of six shaded to the surveyor which shift nurse to and departure. A to required to satisfy the laid out on the flows were left blank and May 1 - One of six shaded to the surveyor which shift nurse to and departure. A to require the surveyor which shift nurse to and departure and the surveyor which shift nurse to and departure. A to require the surveyor which shift nurse to and departure and the surveyor which shift nurse to an all shifts nurse to an action of the surveyor which shifts nurse to an action of the surveyor which shifts nurse to an action of the surveyor which shifts nurse to a surveyor which shifts nurse to an action of the surveyor which shifts nurse to an action of the surveyor which shifts nurse to a	on 6/2/17, at 2:29 p.m. the cist (CP) stated the lorazepam double locked according to the buld of been locked." ENTED RECONCILIATION: a.m. the South medication with licensed practical nurse te locked metallic cabinet was nd when opened contained cotic medications. LPN-A re counted, "between each t was signed as being wheet in the binder housed on s. LPN-A provided the binder ch contained a Change Of ostance Count Sheet dated et contained several columns in arcotic count information shift with additional spacing for sign as they count with arrival of six signatures were the counting requirements as sheet. However, several fields unsigned as follows:				
	shift and PM to NO May 9 - One of six May 12 - One of six May 17 - One of six May 18 - One of six May 24 - One of six May 27 - One of six	x spaces, being the AM to PM C [night] count, was left blank; spaces was left blank; during the medication cart				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EQ	ATEC AT DELANOLI	433 COUN	NTY ROAD 3	0		
THE ESTATES AT DELANO LLC DELANO			MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	should be signed by departing nurse. Li witnessed the carts nurses at change of happens" when couland not completed, sheets should be consignatures for each completed," and so	LPN-A stated the sheets y each oncoming and PN-A stated she had never not being counted by two f shift but added, "I'm sure it unts are sometimes missed Further, LPN-A stated the empleted with double count, "To make sure it was staff are aware, "Who nen it was done last."				
	The North medication carts Change Of Shift Controlled Substance Count sheets dated 5/17, were reviewed and identified the same flowsheet used, however, again, several fields were left blank and unsigned as follows:					
	May 5 - two of six s shift, was left blank May 12 - two of six May 15 - one of six May 26 - two of six AM shift, was left bl	spaces was left blank; spaces was left blank; spaces, again being the entire				
	medications were for Subsequent past m tracking sheets wer which again identifie	count was completed and all bund to be correct with LPN-A. onths of controlled substance re requested and reviewed red several unsigned spaces in cart in which the shift to shift				
	director of nursing (medications should	undocumented. on 6/2/17, at 11:41 a.m. the (DON) stated narcotic be counted, "at every shift mented on the controlled				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE ES	TATES AT DELANO LI	C	ITY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21610	substance count she felt the carts were to they are not signing should be signing to policy," in order to and, "decrease the decrease t	neets. The DON stated she being counted, "[I] just think g." The DON stated the nurses he sheets as, "part of the ensure the count is correct chance of diversion." 1. 6/2/17, at 2:29 p.m. the cist (CP) stated he had redication cart audits within the so and identified the shift to was not being correctly g, "I picked up on that as well." ed the DON of these concerns e staff." Further, CP stated the cumented according to the sure, "rapid detection," was noccurred to, "find out who interview on 6/2/17, at 2:38 and she was never made aware the medication cart narcotic ocumented in the past several vided by the DON on 6/2/17, at in the facility had current medications. Substance Storage policy diffied medications classified as sees were, "subject to special disposal and record-keeping in dance with federal, state and we and regulations." The each shift change, or when d, a physical inventory of all sees is conducted by two	21610			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00933	B. WING		06/0	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT DELANO LL	C	ITY ROAD 3 MN 55328	0		
040.15	CLIMMA DV CTA	<u> </u>		DDOVIDEDIC DI ANI CE CODDECTI	ON	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 56	21610			
	director of nursing of develop systems to appropriately stored or designee could of The DON or design systems to ensure report those results committee for furth	THOD OF CORRECTION: The (DON) or designee could ensure medications are d and accounted for. The DON educate all appropriate staff, nee could develop monitoring ongoing compliance and to the quality assurance er recommendations.				
21810	(21) days.	•	21810			7/17/17
21010	21810 MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate		21010			,,,,,,
	needs. Appropriate care designed to en highest level of phy This right is limited	nal care based on individual e care for residents means nable residents to achieve their sical and mental functioning. where the service is not blic or private resources.				
	by: Based on observation review, the facility for devices were consisted for a	ent is not met as evidenced fon, interview and document ailed to ensure hearing stently offered and audiology a change in hearing ability for 1) who complained about ag.		Corrected		
	Findings include:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
	NAME OF PROVIDER OR SUPPLIER THE ESTATES AT DELANO LLC STREET AE 433 COU DELANO			STATE, ZIP CODE 0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21810	R44's annual Minim 4/26/17, identified Fimpairment. Furthe "Minimal difficulty," hearing aides. During interview on stated he wanted to hearing problems." hearing aides but dhis hearing was, "ki having to "strain monot have hearing ai interview. During subsequent 12:52 p.m. R44 was the hallway. R44 diplace. A recent mental hea 3/31/17, identified Findisorder due to a pavisited with R44 and the questions I aske you." The note was staff, and lacked and been reviewed. When interviewed on ursing assistant (Ninearing and, "deaf" stated she had new aides, and did not a Further, NA-E state little worse," in the preported to the nursaware of it."	num Data Set (MDS) dated R44 had moderate cognitive er, the MDS identified R44 had, with hearing and did not use 5/30/17, at 11:13 a.m. R44 o, "Find out more about my R44 stated he wanted to get idn't know how. R44 stated inda getting bad," and he was ore," with his hearing. R44 did des in place during the observation on 5/31/17, at is seated in his wheelchair in id not have hearing aides in eath Progress Note dated R44 had been seen for a mood ast stroke. The provider did documented, "For most of ed him, he stated 'I can't hear is unsigned by nursing home my evidence hearing issue had on 5/31/17, at 7:48 p.m. NA)-E stated R44 was hard of in at least one ear. NA-E er seen R44 wear hearing use them to her knowledge. Ed R44's hearing seemed, "a coast months and this had been sees, "I believe the nurses are	21810			
	During interview on	6/1/17, at 11:46 a.m. licensed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LI	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	practical nurse (LP has hearing issues aides to her knowle unaware the NA state to be worsening in stated if a resident kept in the medicat LPN-A reviewed the unable to locate an Further, LPN-A state reporting changes needs to see audio R44's Referral/Clinidentified R44 had and identified to haloss." The physicia audiology for hearing completed on 3/15/being identified in hearing identified in hearing hearing physician or referrestesting. When interviewed assistant director of had a history of beil last hearing appoint that long ago." AD hearing aide, howe it. The ADON state hearing aide went, R44's care plan datat risk for impaired vision and hearing. to, "Ensure placem	N)-A stated R44, "Sometimes,", but did not wear any hearing edge. LPN-A stated she was aff had noticed R44's hearing the past months. LPN-A used hearing aides, they were ion carts so they are not lost. e medication cart and was y hearing aides for R44. ted the NA staff should be with hearing as, "maybe he logy." ic Form dated 2/19/16, been seen by the physician ve, "asymmetrical hearing an provided orders, "May go to ng aids [sic]." This was /16, with no further consults	21810			

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Millineso	ita Department of He	ailli				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	2/2047
		00933			06/0	2/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	ITY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	1 0		21810			
	Consultation as needed." The care plan lacked any identified behaviors regarding his hearing aides.					
	p.m. ADON stated sin the medication roremoved it from the there. ADON stated who responded to he declined to use the ADON stated staff or give R44 the hearing behaviors adding, stated the nurses upordered to ensure the been accidentally roownership changed Further, ADON state worsening hearing,	interview on 6/1/17, at 1:16 she found R44's hearing aide form, but was unsure who had a medication cart and placed it if she had just spoken with R44 her with, "I can't hear you," but hearing aide when offered. Was still expected to attempt to ag aide despite his past We need to try." ADON sed to have a treatment his happened, however, it had removed when the facility I and was not carried over. The difference if NA staff had noticed it should have been ferral made to the audiologist by changes."				
		oordination of care with was requested, but none was				
	director of nursing (develop systems to needs are met. The educate all appropr designee could dev ensure ongoing cor	HOD OF CORRECTION: The (DON) or designee could ensure resident hearing a DON or designee could iate staff. The DON or elop monitoring systems to impliance with resident hearing lose results to the quality eee for further				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LI	C	ITY ROAD 3 MN 55328	0		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21995	Maltreatment of Vu Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an internandated reporter requirements of this internally. However esponsible for conreporting requirements of this MN Requirements of the contract of the	Il reporting of maltreatment. all establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a mal reporting procedure, a may meet the reporting section by reporting r, the facility remains applying with the immediate	21995	Corrected		7/17/17
	review, the facility fabuse were identificated and thoroughly investigated and thoroughly investigated and thoroughly investigate (R15) residents (R15) reharm, which resulted (IJ) situation. Furth to the State Agency not following the case (R24) reviewed for The IJ began on 5/during review of a complete detailing the case of the staff and reduced investigate the circular abuse existed the facility administication (DON), and facility notified of the IJ for	ailed to ensure allegations of ed timely, appropriate action ally provide resident protection estigate the allegations for 1 of esulting in high potential for ed in an immediate jeopardy her, the facility failed to report a fall, requiring sutures, when are plan, for 1 of 2 residents		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE		
INAIVIL OI I	-NOVIDEN ON SUFFEIEN		NTY ROAD 3			
THE EST	TATES AT DELANO LL	C	MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 61	21995			
		er scope and severity of D th potential for more than				
	Findings include:					
	R15 had paraplegia depressive disorder and sacral quarterly Minimum indicated R15 was express ideas and non-verbally, make also able to underst comprehension. Fu	cord dated 3/31/17, identified a, anxiety disorder, major r, borderline personality region pressure ulcers. R15's Data Set (MDS) dated 1/6/17, cognitively intact, able to wants both verbally and herself understood, and was tand others with clear urther, the MDS identified R15 assistance of two staff for beders.				
	was positioned lying the head of bed slig interview, at 12:35 pabused, "emotional had been yelled at a nursing assistant (Nouring the evening altercation had occand NA-B came into one evening after pstated there was a staff to document tithere was no currer R15 explained she she was repositioned when she had last be told her the time. R time and NA-C imm became upset, and	on 5/30/17, at 12:22 p.m. R15 g in her bed, in her room, with httly elevated. During o.m. R15 stated she had been ly," by staff. R15 stated she and frequently overheard a NA)-C yell at other residents shift. R15 stated an urred on 5/2/17, in which NA-C to her room to reposition her utting on the call light. R15 board in her room for the NA me when last repositioned, but not time written on the board. wanted to know the last time led. R15 stated she asked been repositioned and NA-C 15 asked NA-C to clarify the nediately raised her voice, told R15 she was not led she was unable to articulate				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00933	B. WING		06/02/2017	
					1 00.0	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	ATES AT DELANO LL	C	ITY ROAD 3	0		
		DELANO,	MN 55328			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21995	Continued From pa	ge 62	21995			
21333	•		21330			
		repositioning time to NA-C,				
		gressively louder." R15 stated				
		om being loud to yelling. R15				
		A-C, "not to yell," at her and				
		not yelling, but if you want me				
		R15 stated she called NA-C "a				
		plied, "I'm not being a bitch, told NA-C she was, "going to				
	write you up." R15 mentioned she did not know NA-C's last name, and as NA-C left the room,					
		out her last name, letter by				
		NA-C later returned to the				
		nce form, with NA-C's name				
		nded it to me stating, "in case				
	you don't know how					
		interview and verbally				
		med the nursing assistant in				
		IA-C, and also stated NA-B				
		d witnessed the entire				
		d she had not turned in the				
		dministration yet, because she				
		out the sequencing of the to ensure it was accurate.				
		he altercation on 5/2/17, after				
		NA-B verbally stated to her				
		t a lot worse, be careful." R15				
		eyor a form titled, Grievance,				
		ompleted. R15 stated she				
		n 5/2/17, after the altercation				
		e sure it was detailed enough.				
		t thinking about the altercation				
		ust messed up." R15 then				
		"How can I report if I don't get				
		idditional R15 identified she				
		ition that she may be given a				
	discharge notice if	she complained.				
	D4E state d size : 40	t ti				
		e altercation occurred on				
	່ວ/∠/ ⊦/, no otner sta	aff, including the DON,				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE ESTATES AT DELANOLLC			MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	licensed social work had come to talk to 5/2/17, between he the altercation with R15 stated she had members talking at which she emphasi bothered her as we LPN-A told her NA-Further, R15 stated accountable," at the "anyone would do a if she completed the R15 added the adm discharge her from was hospitalized. R upset by this, as sh the attempt at dischombudsman involvappeal for the facility action, and the discountable when interviewed and R15 which hap NA-C and R15 had repositioning when at her. NA-B stated NA-C make her point, and regroup. NA-B stated NA-C make her point, and regroup. NA-B stated NA-C that was unanurse was when query when interviewed a stated she recalled R15 on 5/2/17, and working on the same	ker (LSW), or administrator, her about the altercation on rself and NA-C. R15 stated NA-C "made me feel terrible." It overheard several other staff pout the altercation on 5/2/17, zed this had upset and staff. Adding, after the altercation C had a "bad temper." It she felt, "no one is ever held as facility and she questioned if, anything," about her grievance are form and had turned it in. Ininistration had attempted to the facility in 2/17, while she at 15 stated she continued to be a had not come to terms with harge. R15 stated she got the red, who assisted in filing an the altercation between NA-C pened on 5/2/17. NA-B stated argued about her turning and R15 accused NA-C of "yelling" at they were, "stating a fact." the tried repeatedly to verbally discharge was resorted the event to a ble to remember who the	21995			

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DON, but could not recall the day and/or time she

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/02/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	THE ESTATES AT DELANO LLC 433 COL			0		
(V4) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	MN 55328	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21995	Continued From page 64		21995			
	and NA-B about red did not believe them been last reposition cussed at the aides NA-C stated she wanswer about her re R15, "You're not tal NA-C stated she proto fill out with her nait to the resident be difficult to spell." No "fucking bitch." NA "she could be a bitch." During a subseque	ated R15 had argued with her positioning. NA-C stated R15 in regarding the times R15 had led. NA-C stated R15 verbally and accused her of yelling. The astrying to give R15 an epositioning adding she told king my answer." Further, ovided R15 a grievance form ame on the form before giving cause "my last name is A-C stated R15 called her a -C stated she told R15 that, bh, but was trying not to be."				
	p.m. R15 again expoccurred when R15 R15 stated the incide around 7:00 or 8:00 and R15 repeated for time she was lying and the need for rethe altercation as a went back and forth how R15 felt in NAstated, "nervous and not like how the incompared when R15 representations are the stated of the stat	blained the altercation that balleged abuse by facility staff. dent happened on 5/2/17, by p.m., after the evening meal, her concerns about the length in bed in the same position positioning. R15 described in argument with NA-C that in and escalated. When asked in a concerns about the length in argument with NA-C that in and escalated. When asked in a concern a co				
	(RN)-A at 21:42 (9: [nursing assistant r that when staff mer resident, Resident repo [repositioning] res [resident] that s and repositioned re	e dated 5/2/17, authored by 42 p.m.) indicated, "NAR egistered] reported to writer mber went to reposition began questioning NAR about scheduling. NAR explained to he had just began her shift s when she arrived and now, to writer, prior to eve meal ne. Res became				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT DELANO LI	C	NTY ROAD 3 MN 55328	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	argumentative with assured res that share you arguing wit Staff member state only told you what I you yelling at me, y stated she was not another staff member. NAR reporting state to become calm an increasingly agitate bitch. Writer went the res is sleeping." R15's progress not licensed practical in "Resident will not a when it was time to Review of R15's professional state of the related follow up to Facility staff schedul were reviewed, and NA-C was schedul were reviewed, and NA-C was schedul was sched	staff member. Staff member are on time. Res stated 'Why h me, you don't have to yell.' ad, 'I was not yelling or mad, I know.' Res replied 'Why are you are a bitch!', staff member angry or yelling. There was ber, NAR in the room as well. and that she will allow res time and return as res was becoming and and calling Staff member a pores room a while after and the dated 5/4/17, authored by hurse (LPN)-B indicated, llow [NA-C] into her room or repositioning."	21995			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TUE EQ1	TATES AT DEL ANO LL	433 COUN	ITY ROAD 3	0		
THE ESTATES AT DELANO LLC DELANO			MN 55328			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			D BE	(X5) COMPLETE DATE	
21995	Continued From page 66		21995			
	her. When surveyor "emotionally abused that was the first "IDON reviewed the acknowledged she R15 since the incidence have someone DON stated that hawould have talked the resident, "This it me." The DON acallegedly signed, dagrievance form about stated had she known pulled NA-C off the investigation, and a resident. The DON 24/7". The DON states	did not see any follow up with ent, and also stated she did talk to the resident (R15). The d she read the note, she o the nursing assistants and s what we used to do all the lded she was unaware NA-C ated and handed R15 a ut the incident. The DON wn about this, she would have floor, pending an lso would have talked to the stated, "Call me, I'm on call ated she talked to NA-C but er. She further stated				
	administrator stated explained to him. That a difficult time of recently had a room feelings toward him R15's incident on 5, there might have be between R15 and on the stated they would her side of the the stated they would put allegation on lead and replace them, during their investiges.	5/31/17, at 5:52 p.m. the the incident had just been the administrator stated R15 with staff, mentioning that R15 in change and had hard and the DON. In regard to 2/2/17, the administrator stated een a verbal exchange IA-C, and it was his had a disagreement. The difference to talk to [R15] to get story." The administrator ut the staff person involved in ave during the investigation to protect the other residents," ation. The administrator also immediate education				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00933	B. WING		06/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT DELANO LL	C	ITY ROAD 3	0		
		DELANO,	MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21995	5 Continued From page 67		21995			
	regarding dignity, p	atience and resident rights.				
	p.m. the administra with NA-C and susptalked with R15, who made me feel threat stated we would "m." When interviewed that been implement LPN-C stated staff routine training on vulnerable adults as she had not complestated she had not past few days regardabuse, timely reporresident allegations she witnessed or substween staff and at to be verbal abuse, resident involved and the staff person invasing training any staff person invasing training and she with residents befor always the nicest," around here in genonicest." LPN-C staff remove or suspendiallegations of potents she, "wouldn't fe further added the staff person invasing training trainin	Int interview on 5/31/17, at 8:02 tor stated he had just visited bended her because he just to told me "this staff member attened." The administrator ake things right for [R15]." To ensure the IJ removal plan atted on 6/2/17, at 10:43 a.m. awas required to complete various topics, including and abuse prevention, however, atted it yet for the year. LPN-C received any training in the rding identification of potential ting of it or how to handle of abuse. LPN-C stated if uspected an altercation a resident and it had potential she would visit with the ministration. LPN-C stated in, nor sure how to handle rolved in a potential altercation d, "words with the aides." and noticed staff interacting re and, "the tone in itself isn't further adding, "The tone aral, by staff, is not always the ted she would not immediately a staff member who had attal abuse made against them el authorized to do that," and taff, "probably wouldn't listen				
		ther, LPN-C stated she had about the tone of staff, "in the and social worker.				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00933	B. WING		06/0	2/2017
		00333			1 00/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE ECT	ATEC AT DEL ANO LL	433 COUN	ITY ROAD 3	0		
IHE ESI	TATES AT DELANO LL	.C DELANO,	MN 55328			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				BEI IOIEIVOT)		
21995	Continued From pa	ge 68	21995			
	A magaga was left	t for registered pures (DN) A				
		t for registered nurse (RN)-A				
		n 6/1/17, at 1:15 p.m. who did				
		ephone call. During a				
		on 6/5/17, at 1:16 p.m. RN-A with R15 on 5/2/17, and				
		ation, checked on R15 but R15				
		A stated she checked back				
		at happened earlier and stated				
	R15 told her about the incident. However, RN-A					
	could provide details of the conversation she had with R15. RN-A stated R15 never mentioned					
		abuse, however, stated the				
		RN-A stated she did not				
		nd conversation she had with				
		vior was typical for R15. RN-A				
		s a favorite" for R15 up until				
		she took no further actions,				
		need to call the administrator				
	or DON about this i					
	Although the facility	acknowledged the altercation				
		NA-C on 5/2/17, the facility's				
		ntify R15's potential abuse that				
		ntly take steps to ensure the				
		ediately pending any finding,				
		ghly investigate the complaint				
		ation. There was no				
	investigation compl	eted to determine possible				
	abuse, nor did the f	acility protect other residents				
	as identified by the	facility policy.				
		pardy which began 5/2/17, was				
		at 3:56 p.m. after the facility				
		oval plan which included:				
		with R15, revised the plan of				
	-	the allegation to the State				
	Agency;					
		ff on leave pending the				
	outcome of the inve					
	-screened all reside	ents regarding any potential				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
00933		B. WING		06/0	2/2017	
		00933			1 00/0	2/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TUE	ATEO AT DEL ANO LL	433 COUN	NTY ROAD 3	0		
THE EST	TATES AT DELANO LL	DELANO,	MN 55328			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIEIGOT)		
21995	Continued From pa	ge 69	21995			
	•					
	abuse;					
		appropriate and timely				
		andling of resident allegations				
	of abuse;	I PC I Pc f P				
		t additional information				
	0	an upcoming resident council				
	meeting.					
		social services and other staff				
		observations during care				
	ensure appropriate	taff, and interview residents to				
		dministrator indicated,				
		mily will be asked about any				
		al abuse during care				
	conferences.	ar abase daring ourc				
	comoronoco.					
	The facility policy. A	Abuse Prevention/Vulnerable				
		4/17, indicated in the				
		g section that "All Staff was				
		orting any situation that is				
		or neglect." The policy				
		nurse will be notified				
	immediately, asses	s the situation to determine if				
	any emergency trea	atment or action is required,				
	and complete an in	•				
		learning of the incident, staff				
		steps to protect residents				
		equent incident of misconduct				
		natter is being investigated."				
		e will also ensure that any				
		abuse is eliminated by taking				
		actions: if this is staff to				
		staff person will be excused				
	from position until t	he investigation is completed."				
	The market of the first	and an above of the t				
		, when abuse or neglect was				
		ed, appropriate corrective				
		en and notification procedures				
		which indicated "suspected				
	abuse shall be repo	orted to the administrator				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00933	B. WING		06/0	2/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE ESTATES AT DELANO LLC 433 COUNTY ROAD 30 DELANO, MN 55328						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	immediately and O reporting process reporting the suspici would begin immediately. The investing "interviewing staff, to the incident" and the investigation with of procedure, training staff, etc.)" R24's annual MDS had severe cognitive identified R24 needs bed mobility, transfer identified diagnosed dementia and anxieth had two or more fassessment dated. R24's care plan rever had a potential for included use of meresulting in an intrain impaired mobility placing him at high identified R24 had since the initial fall. bedside was listed undated Group D midentified a floor marked. A progress note daindicated R24's bed and staff found him floor" in a pool of bifrom a laceration of the interview of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in a pool of bifrom a laceration of the initial form in the	HFC (the State Agency) online not later than 2 hours after on of abuse." An investigation diately, led by the investigation diately, led by the investigation diately, led by the investigation diation may include residents, or other witnesses a "corrective action based on all be completed (e.g., changeing, discipline or discharge of dated 4/19/17, indicated R24 we impairment. The MDS ded extensive assistance for der and ambulation. The MDS is of hypertension, arthritis, ety. The MDS indicated R24 dis without injury since the last 1/25/17. It wised on 3/8/17, identified R24 falls/accidents. Risk factors dications, pain, a fall 6/14, cranial hemorrhage, resulting w/cognition, impulsivity, and der risk for falls. The care plan fallen several more times A fall mat at the resident's as an intervention. R24's hursing assistant sheet at as a safety intervention for ted 5/11/17, at 3:13 a.m. di alarm went off at 1:20 a.m. in lying on his stomach "on the lood. The blood was coming	21995			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00933	B. WING		06/0	2/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 COUNTY ROAD 30 THE ESTATES AT DELANO LLC						
THE EST	IAIES AI DELANO LL	DELANO,	, MN 55328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21995	5/11/17, indicated the sutures to a head land land land land land land land la	ne resident received seven acceration. on 5/31/17, at 7:37 p.m. R24 hout a fall mat on the floor by 5/31/17, at 7:56 p.m. NA-H was not on the floor, looked for a unable to locate it. NA-H nd went to help another nat was placed by R24's 5/31/17, at 8:06 p.m. trained A)-A stated R24 needed to his bedside. 6/2/17, at 10:33 a.m. the progress note regarding the 7, and stated it did not look s on the floor at the time of med. The DON further stated until 6/2/17, while reviewing he resident was found on the fall mat. The DON proceeded westigation and stated it was there were no further details	21995			
	when reviewing falls interventions the fall always reviewed, as know the investigat. The DON stated the prior to the fall were if the staff were not 5/11/17, the fall sho	in 5/11/17. The DON stated is and implementing new all investigation sheet was not and this was why she did not ion had not been completed. It is assessed fall interventions is expected to be followed and following the care plan on all will have been reported to the coroughly investigated, per the				

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	A. BUILDING:		COMPLETED		
00933	B. WING		06/02/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
THE ESTATES AT DELANOLLC	NTY ROAD 30 , MN 55328				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTE		
The facility Abuse Prevention/Vulnerable Adult Plan dated 4/17, directed incidents that must be reported to the State Agency include not following resident care plan. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure allegations of resident abuse/neglect/misappropriation/maltreatment is reported to the administrator and state agency in a timely manner, residents are immediately protected, the incident is thoroughly investigated with reports of the investigative findings reported to the appropriate places. The administrator or designee could ensure all staff are appropriately educated and residents are aware of how to report allegations without fear of reprisal. The administrator or designee could monitor the systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995				

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