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

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

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

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

Sincerely,

Holly Kranz, RN, LNHA, Mankato Unit Supervisor
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

MDH
Minnesota
Department
of Health

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

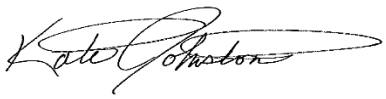
Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

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.

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

MDH
Minnesota
Department
of Health

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.

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

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BBZQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00933

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245336**

2. STATE VENDOR OR MEDICAID NO. (L2) **655371100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT DELANO LLC**
(L4) **433 COUNTY ROAD 30**
(L5) **DELANO, MN** (L6) **55328**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2017**

6. DATE OF SURVEY **06/02/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B***,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date : Bruce Melchert, HFE NE II 07/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 07/24/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **01111** (L31)

30. REMARKS
Emailed ROCHI Annual Waiver K521 - 07/25/2017 Co.
Posted 07/25/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

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

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

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

Substandard Quality of Care - 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;

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

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

Informal Dispute Resolution - 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/30/17 to 6/2/17, a recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). The Estates at Delano was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F225 when the facility failed to ensure appropriate action was taken to immediately provide resident protection and thoroughly investigate potential allegations of abuse, which resulted in the high potential for serious harm. The IJ began on 5/2/17, and was removed on 6/2/17, at 3:56 p.m. when the facility implemented a removal plan which included conducting thorough investigations for R15, screening of all residents regarding any abuse, and educating staff on appropriate and timely identification of abuse and handling of resident allegations of abuse. An extended survey was completed at the facility on 6/1/17 and 6/2/17. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with	F 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (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 (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 157		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This 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 ulcers and did not currently have pressure ulcers. R18's Skin Evaluation dated 3/29/17, indicated a Stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on the right heel measuring 2 centimeters (cm) x 2 cm. The note indicated it was a blister. The assessment also	F 157	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 157 a. R18 was discharged from the facility on 3/31/2017. R12 transferred rooms on 1/15/2017. Review Room/Roommate change policy with responsible party of R12on 6/29/2017. b. Audit of all residents skin completed to ensure no new skin issues have been identified. Audit of all residents that have had room changes in past 60 days completed to ensure room change notification has been given. Room/Roommate change Policy reviewed with residents at resident council on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 identified a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) to the left heel measuring 2 cm x 1 cm x 0.3 cm. The assessment did not include any further description of the pressure ulcers, interventions, physician notification or treatment initiated. R18's medical record lacked evidence the physician was notified of the change in condition of R18's skin. On 6/2/17, at 11:31 a.m. a telephone message was left for R18's physician. On 6/5/17, at 1:38 p.m., via telephone, R18's physician stated she was not aware R18 developed two Stage 2 pressure ulcers. The physician further stated she would expect to be notified when a resident developed pressure ulcers for appropriate treatment. LACK OF NOTICE WITH ROOM CHANGE: R12's significant change Minimum Data Set (MDS) dated 5/2/17, identified R12 had severe cognitive impairment and was totally dependent on staff for transfers and off-unit locomotion. During interview on 5/30/17, at 2:01 p.m. R12's responsible party, family member (FM)-A stated R12 had changed rooms within the past nine months and she was not notified of this change prior to it happening. FM-A stated she would have liked to had been told of it prior, instead of showing up to the nursing home to visit and finding R12 not in the same room adding, "It would be helpful to improve communication from here [nursing home] to home."	F 157	6/27/2017. c. Policy and procedure for physician notification of change reviewed and remains current. All licensed nursing staff will be provided education regarding notification of physician on change in conditions. Policy and procedure for Room/Roommate change reviewed and remains current. Education to Social services regarding Room/Roommate change policy. d. Director of Nursing or designee to complete an audit on 5 residents Weekly skin inspection to ensure no new skin issues have been identified and if noted a physician update was performed. Social Services or designee to complete an audit of all residents that were issued room changes to ensure they were properly notified of the room change. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 R12's undated electronic medical record (EMR) census information identified R12 changed rooms in 1/17. R12's medical record was reviewed and lacked any evidence FM-A was told of the room change prior to it occurring. When interviewed on 6/2/17, at 8:54 a.m. licensed social worker (LSW)-A stated she reviewed R12's medical record and was unable to locate any documentation demonstrating R12's responsible party had been notified of the room change, "I didn't find any." Further, LSW-A stated FM-A should have been notified so, "The family knows where to find them," and are not placed in a situation to wonder, "Where did my loved one go," when they next come visit as happened to FM-A. A GL Resident Room Relocation policy (in effect at the time of room change for R12) dated 12/1/16, identified a resident, "has the right to receive written notice ... before the resident's room or room mate in the Living Center is changed." The policy directed social services staff to provide notice to the resident, "and his or her legal representative or interested family member with a written notice and documenting in the medical record." A policy on notification of change was requested and not received.	F 157		
F 205 SS=D	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility	F 205		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 205	Continued From page 5 transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notice of bed hold policy was provided timely after emergent transfer for 2 of 5 residents (R79, R16) reviewed for admission, transfer and discharge practices. Findings include: R79's 5-day Minimum Data Set (MDS) dated	F 205	F 205 a. R 79 and R 16 were transferred to the hospital without proper bed hold. Reviewed the bed hold policy with the responsible party of R 79 and R 16 on 6/29/2017. b. Audit of all residents that have been transferred to the hospital in past 60 days	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 205	Continued From page 6 4/27/17, identified R79 had severe cognitive impairment and was dependent on staff for transfers. When interviewed on 5/30/17, at 2:22 p.m. R79's responsible party and family member (FM)-C stated R79 was recently hospitalized from the nursing home. FM-C stated she was not provided any type of written notice from the nursing home regarding their bed hold policy adding, "I never knew there was a policy." R79's progress notes dated 5/21/17, to 5/28/17, identified R79 was transferred to the hospital on 5/23/17, on an emergent basis due to seizure activity and readmitted to the nursing home on 5/27/17 (four days later). The progress notes lacked any evidence FM-C had been told of the facility bed hold policy either in writing or verbally. R79's medical record was reviewed and lacked any documented evidence FM-C had been provided written notice of the facility bed hold policy with 24 hours of R79's hospital transfer as required. When interviewed on 6/1/17, at 8:19 a.m. licensed practical nurse (LPN)-A reviewed the process for sending someone to the hospital. LPN-A stated staff was supposed to print a medication list, have a physician order and also, "Have a bed hold sheet for them to sign." LPN-A stated staff was expected to get the bed hold policy notice signed by family or the resident at the time of transfer. During interview on 6/1/17, at 9:04 a.m. licensed social worker (LSW)-A stated staff, "are supposed to," have a bed hold policy signed	F 205	completed to ensure proper bed hold policy has been given. Bed hold policy reviewed at resident council on 6/27/2017 and with every new admission. c. Policy and procedure of Bed-Hold Policy for Hospital Transfer and Therapeutic Leave policy reviewed and remains current. All licensed nursing staff will be educated on the Bed-Hold Policy for Hospital Transfer and Therapeutic Leave. d. Social Services or Designee to complete weekly audit of all residents transferred to the hospital to ensure proper bed hold has been given. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 205	Continued From page 7	F 205		

when they transfer to the hospital. LSW-A stated she reviewed R79's medical record and was unable to locate any evidence FM-C had been provided one and stated, "not that I can find." Further, LSW-A stated a signed bed hold notice was important to acquire, as without it residents may be discharged elsewhere from the hospital or may continue to be billed by the nursing home for the bed hold against their wishes.
R16's quarterly Minimum Data Set (MDS) dated 1/4/17, indicated R16 was severely, cognitively impaired, and totally dependent upon staff for transfers.

Review of the hospital discharge summary revealed that R16 was transferred to the hospital for pneumonia and eventually admitted.

R16's nursing progress note dated 5/29/17, indicated R16 was transferred to the hospital. Futher review of the progress notes 10 days past the hospital admision did not indicate that a notice of bed hold was given to the family or the resident.

During an interview with family member (FM)-2 on 5/30/17, at 11:05 a.m., FM-2 confirmed that a bed hold policy was not given at the time of discharge to the hospital. FM-2 was observed to be at the facility to visit R16 every day of the survey, and confirmed a daily visit with R16.

During interview on 6/1/17 at 2:21 p.m., registered nurse (RN)-1 revealed that a bed hold agreement was not given, and there was no evidence of a bed hold in the resident record.

A facility Bed-Hold Policy for Hospital Transfer and Therapeutic Leave dated 12/16, identified it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 205	Continued From page 8 was the facility policy to, "inform the resident, resident representative and/or responsible party verbally and in writing of the policies regarding hospital transfers, therapeutic leave, discharge and return." The policy directed staff to contact the responsible party and, "remind them of the bed-hold policy," then, "A form is provided to acknowledge receipt of the bed hold policies and procedures for return." Further, the policy identified staff should document this in the progress notes.	F 205		
F 225 SS=J	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a	F 225		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9 nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious 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 is 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 225	F 225	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10 review, the facility failed to ensure allegations of abuse were identified timely, appropriate action taken to immediately provide resident protection and thoroughly investigate the allegations for 1 of 1 residents (R15) resulting in high potential for harm, which resulted in an immediate jeopardy (IJ) situation. Further, the facility failed to report to the State Agency a fall, requiring sutures, when not following the care plan, for 1 of 2 residents (R24) reviewed for accidents. The IJ began on 5/2/17, following interview and during review of a documented altercation between staff and R15, the facility failed to identify potential verbal abuse, take action to immediately protect R15, or thoroughly investigate the circumstances to determine if actual abuse existed. On 5/31/17, at 8:10 p.m., the facility administrator, director of nursing (DON), and facility regional nurse consultant were notified of the IJ for R15. The IJ was removed on 6/2/17, at 3:56 p.m., however, non-compliance remained at the lower scope and severity of D which is isolated with potential for more than minimal harm. Findings include: R15's admission record dated 3/31/17, identified R15 had paraplegia, anxiety disorder, major depressive disorder, borderline personality disorder and sacral region pressure ulcers. R15's quarterly Minimum Data Set (MDS) dated 1/6/17, indicated R15 was cognitively intact, able to express ideas and wants both verbally and non-verbally, make herself understood, and was also able to understand others with clear comprehension. Further, the MDS identified R15 required extensive assistance of two staff for bed	F 225	a. R 15 allegations were thoroughly investigated per policy. b. Residents educated during Resident Council on 6/27/2017 on their rights and responsibilities of being in a safe environment and their rights regarding the Abuse Prevention/Vulnerable Adult Plan. All residents were interviewed to ensure that they felt safe in the environment and all abuse allegations were investigated thoroughly. c. Policy and procedure for Abuse Prevention/Vulnerable Adult Plan policy reviewed and remains current. All staff were educated to the Abuse Prevention/Vulnerable Adult Plan. Education on completing a thorough investigation completed administrator, director of nursing, social services, and assistant director of nursing. d. Administrator or Designee will complete an audit with 3 random residents, via interview, to ensure they feel safe in the facility and abuse allegations are investigated timely and thoroughly. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations. a. R24's fall was investigated and it was determined that the care plan was followed at the time of the fall. b. All falls since survey exit were audited to ensure care plan was followed at the time of the fall. c. Policy and procedure for Assessing Falls and their Causes reviewed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	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 it went very quick from being loud to yelling. R15 stated she 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 you don't know how to spell."	F 225	remains up-to-date. Education to all licensed nursing staff on policy and overview of falls and ensuring care plan is followed at the time of a fall and procedure for notification if care plan is not being followed. d. Director of Nursing or designee complete an audit of a random selection of residents to ensuring care plan is followed at the time of a fall and procedure for notification if care plan is not being followed. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 12	F 225		

R15 continued the interview and verbally identified and confirmed the nursing assistant in this altercation as NA-C, and also stated NA-B was in her room and witnessed the entire incident. R15 stated she had not turned in the grievance form to administration yet, because she was concerned about the sequencing of the events and wanted to ensure it was accurate. R15 stated during the altercation on 5/2/17, after NA-C left the room, NA-B verbally stated to her that, NA-C, "can get a lot worse, be careful." R15 presented the surveyor a form titled, Grievance, that was partially completed. R15 stated she began filling it out on 5/2/17, after the altercation but wanted to make sure it was detailed enough. R15 stated she kept thinking about the altercation in her head and, "I just messed up." R15 then paused and stated, "How can I report if I don't get it exactly right." In additional R15 identified she was afraid of retaliation that she may be given a discharge notice if she complained.

R15 stated since the altercation occurred on 5/2/17, no other staff, including the DON, licensed social worker (LSW), or administrator, had come to talk to her about the altercation on 5/2/17, between herself and NA-C. R15 stated the altercation with NA-C "made me feel terrible." R15 stated she had overheard several other staff members talking about the altercation on 5/2/17, which she emphasized this had upset and bothered her as well. Adding, after the altercation LPN-A told her NA-C had a "bad temper." Further, R15 stated she felt, "no one is ever held accountable," at the facility and she questioned if, "anyone would do anything," about her grievance if she completed the form and had turned it in. R15 added the administration had attempted to discharge her from the facility in 2/17, while she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 13	F 225		

was hospitalized. R15 stated she continued to be upset by this, as she had not come to terms with the attempt at discharge. R15 stated she got the Ombudsman involved, who assisted in filing an appeal for the facility's "emergency discharge" action, and the discharge was rescinded.

When interviewed on 5/30/17, at 3:49 p.m. NA-B stated she recalled the altercation between NA-C and R15 which happened on 5/2/17. NA-B stated NA-C and R15 had argued about her turning and repositioning when R15 accused NA-C of "yelling" at her. NA-B stated they were, "stating a fact." NA-B stated NA-C tried repeatedly to verbally make her point, and walked out of the room to regroup. NA-B stated she reported the event to a nurse, but was unable to remember who the nurse was when questioned.

When interviewed on 5/30/17, at 4:03 p.m. NA-C stated she recalled the altercation she had with R15 on 5/2/17, and had reported it to the nurse working on the same night. NA-C stated after the incident she also reported the altercation to the DON, but could not recall the day and/or time she reported it. NA-C stated R15 had argued with her and NA-B about repositioning. NA-C stated R15 did not believe them regarding the times R15 had been last repositioned. NA-C stated R15 verbally cussed at the aides and accused her of yelling. NA-C stated she was trying to give R15 an answer about her repositioning adding she told R15, "You're not taking my answer." Further, NA-C stated she provided R15 a grievance form to fill out with her name on the form before giving it to the resident because "my last name is difficult to spell." NA-C stated R15 called her a "fucking bitch." NA-C stated she told R15 that, "she could be a bitch, but was trying not to be."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14	F 225		

During a subsequent interview on 5/31/17, at 4:07 p.m. R15 again explained the altercation that occurred when R15 alleged abuse by facility staff. R15 stated the incident happened on 5/2/17, around 7:00 or 8:00 p.m., after the evening meal, and R15 repeated her concerns about the length of time she was lying in bed in the same position and the need for repositioning. R15 described the altercation as an argument with NA-C that went back and forth and escalated. When asked how R15 felt in NA-C's presence now, R15 stated, "nervous and afraid." R15 added she did not like how the incident on 5/2/17, made her feel, and stated, "I felt threatened that night."

R15's progress note dated 5/2/17, authored by (RN)-A at 21:42 (9:42 p.m.) indicated, "NAR [nursing assistant registered] reported to writer that when staff member went to reposition resident, Resident began questioning NAR about repo [repositioning] scheduling. NAR explained to res [resident] that she had just began her shift and repositioned res when she arrived and now, at time of reporting to writer, prior to eve meal scheduling is on time. Res became argumentative with staff member. Staff member assured res that she on time. Res stated 'Why are you arguing with me, you don't have to yell.' Staff member stated, 'I was not yelling or mad, I only told you what I know.' Res replied 'Why are you yelling at me, you are a bitch!', staff member stated she was not angry or yelling. There was another staff member, NAR in the room as well. NAR reporting stated that she will allow res time to become calm and return as res was becoming increasingly agitated and calling Staff member a bitch. Writer went to res room a while after and res is sleeping."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 15	F 225		

R15's progress note dated 5/4/17, authored by licensed practical nurse (LPN)-B indicated, "Resident will not allow [NA-C] into her room when it was time to repositioning."

Review of R15's progress notes from 5/2/17 to 5/31/17, lacked additional investigation and documentation of the altercation on 5/2/17, or any related follow up to this occurrence.

Facility staff schedules from 5/1/17 to 5/31/17 were reviewed, and indicated the following:
NA-C was scheduled on the following days: 5/2, 5/4, 5/6, 5/7, 5/8, 5/9, 5/13, 5/14, 5/16, 5/19, 5/22, 5/23, 5/25, 5/26, 5/30, and 5/31/17.
NA-B was scheduled on the following days: 5/2, 5/5, 5/6, 5/7, 5/10, 5/11, 5/12, 5/15, 5/16, 5/17, 5/18 5/19, 5/20, 5/24, 5/25, 5/26, and 5/30/17.

When interviewed on 5/31/17, at 5:02 p.m. the DON discussed the altercation which occurred on 5/2/17, between R15 and NA-C. The DON stated the first time she learned of the altercation between R15 and NA-C was "last Thursday" (5/25/17) when NA-C approached her. The DON stated no staff member had immediately called her. When surveyor reported R15 felt she was "emotionally abused" the DON reacted and stated that was the first "I have heard about this." The DON reviewed the progress notes and acknowledged she did not see any follow up with R15 since the incident, and also stated she did not have someone talk to the resident (R15). The DON stated that had she read the note, she would have talked to the nursing assistants and the resident, "This is what we used to do all the time." The DON added she was unaware NA-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 16	F 225		

allegedly signed, dated and handed R15 a grievance form about the incident. The DON stated had she known about this, she would have pulled NA-C off the floor, pending an investigation, and also would have talked to the resident. The DON stated, "Call me, I'm on call 24/7". The DON stated she talked to NA-C but did not take it further. She further stated somehow she missed the note.

During interview on 5/31/17, at 5:52 p.m. the administrator stated the incident had just been explained to him. The administrator stated R15 had a difficult time with staff, mentioning that R15 recently had a room change and had hard feelings toward him and the DON. In regard to R15's incident on 5/2/17, the administrator stated there might have been a verbal exchange between R15 and NA-C, and it was his understanding they had a disagreement. The administrator stated the DON had talked with NA-C, but, "I would have to talk to [R15] to get her side of the the story." The administrator stated they would put the staff person involved in the allegation on leave during the investigation and replace them, "to protect the other residents," during their investigation. The administrator also stated he would do immediate education regarding dignity, patience and resident rights.

During a subsequent interview on 5/31/17, at 8:02 p.m. the administrator stated he had just visited with NA-C and suspended her because he just talked with R15, who told me "this staff member made me feel threatened." The administrator stated we would "make things right for [R15]."

When interviewed to ensure the IJ removal plan had been implemented on 6/2/17, at 10:43 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 17	F 225		

LPN-C stated staff was required to complete routine training on various topics, including vulnerable adults and abuse prevention, however, she had not completed it yet for the year. LPN-C stated she had not received any training in the past few days regarding identification of potential abuse, timely reporting of it or how to handle resident allegations of abuse. LPN-C stated if she witnessed or suspected an altercation between staff and a resident and it had potential to be verbal abuse, she would visit with the resident involved and report the situation to the charge nurse or administration. LPN-C stated she was not trained in, nor sure how to handle any staff person involved in a potential altercation as she tried to avoid, "words with the aides." LPN-C stated she had noticed staff interacting with residents before and, "the tone in itself isn't always the nicest," further adding, "The tone around here in general, by staff, is not always the nicest." LPN-C stated she would not immediately remove or suspend a staff member who had allegations of potential abuse made against them as she, "wouldn't feel authorized to do that," and further added the staff, "probably wouldn't listen to me anyway." Further, LPN-C stated she had reported concerns about the tone of staff, "in the past," to the DON and social worker.

A message was left for registered nurse (RN)-A during the survey on 6/1/17, at 1:15 p.m. who did not respond to a telephone call. During a telephone interview on 6/5/17, at 1:16 p.m. RN-A stated she worked with R15 on 5/2/17, and following the altercation, checked on R15 but R15 was sleeping. RN-A stated she checked back and asked R15 what happened earlier and stated R15 told her about the incident. However, RN-A could provide details of the conversation she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 18	F 225		

with R15. RN-A stated R15 never mentioned emotional or verbal abuse, however, stated the resident felt safe. RN-A stated she did not document the second conversation she had with R15, and this behavior was typical for R15. RN-A stated [NA-C] "was a favorite" for R15 up until then. RN-A stated she took no further actions, and did not feel any need to call the administrator or DON about this incident.

Although the facility acknowledged the altercation between R15 and NA-C on 5/2/17, the facility's inaction to fully identify R15's potential abuse that day and subsequently take steps to ensure the safety of R15 immediately pending any finding, and failed to thoroughly investigate the complaint to make a determination. There was no investigation completed to determine possible abuse, nor did the facility protect other residents as identified by the facilty policy.

The immediate jeopardy which began 5/2/17, was removed on 6/2/17, at 3:56 p.m. after the facility implemented a removal plan which included:
- administrator met with R15, revised the plan of care, and reported the allegation to the State Agency;
-placed alleged staff on leave pending the outcome of the investigation;
-screened all residents regarding any potential abuse;
-educated staff on appropriate and timely identification and handling of resident allegations of abuse;
-planned to present additional information regarding abuse at an upcoming resident council meeting.
- facility designated social services and other staff to conduct random observations during care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 19	F 225		

provision to audit staff, and interview residents to ensure appropriate care is provided.
-Additionally, 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 to the incident" and "corrective action based on the investigation will be completed (e.g., change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 20	F 225		

of procedure, training, discipline or discharge of staff, etc.)"

R24's annual MDS dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfer and ambulation. The MDS 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 care plan revised on 3/8/17, identified R24 had a potential for falls/accidents. Risk factors included use of medications, pain, a fall 6/14, resulting in an intracranial hemorrhage, resulting in impaired mobility/cognition, impulsivity, and placing him at higher risk for falls. The care plan identified R24 had fallen several more times since the initial fall. A fall mat at the resident's bedside was listed as an intervention. R24's undated Group D nursing assistant sheet identified a floor mat as a safety intervention for R24.

A progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off at 1:20 a.m. and staff found him lying on his stomach "on the floor" in a pool of blood. The blood was coming from a laceration on his head.

R24's emergency room discharge report dated 5/11/17, indicated the resident received seven sutures to a head laceration.

During observation on 5/31/17, at 7:37 p.m. R24 was lying in bed without a fall mat on the floor by the bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 21	F 225		

During interview on 5/31/17, at 7:56 p.m. NA-H stated the fall mat was not on the floor, looked for the fall mat and was unable to locate it. NA-H then left the room and went to help another resident. No floor mat was placed by R24's bedside.

During interview on 5/31/17, at 8:06 p.m. trained medication aid (TMA)-A stated R24 needed to have a fall matt at his bedside.

During interview on 6/2/17, at 10:33 a.m. the DON reviewed the progress note regarding the the fall dated 5/11/17, and stated it did not look as if the fall mat was on the floor at the time of the fall as care planned. The DON further stated she did not realize until 6/2/17, while reviewing the progress note the resident was found on the floor and not on his fall mat. The DON proceeded to look for the fall investigation and stated it was not completed and there were no further details regarding the fall on 5/11/17. The DON stated when reviewing falls and implementing new interventions the fall investigation sheet was not always reviewed, and this was why she did not know the investigation had not been completed. The DON stated the assessed fall interventions prior to the fall were expected to be followed and if the staff were not following the care plan on 5/11/17, the fall should have been reported to the state agency and thoroughly investigated, per the facility policy.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 22	F 226		
F 226 SS=F	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and	F 226	F 226	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 23 procedures for abuse prohibition to include immediate reporting of allegations of abuse and mistreatment, failed to protect residents during the investigation, and thoroughly investigate 1 of 1 residents (R15) allegations of abuse. Further, the facility failed to report to the State Agency a fall with injuries as a result of not following the care plan, for 1 of 2 residents (R24) reviewed for accidents. This had potential to affect all 35 residents residing in the facility and resulted in substandard quality of care (SQC) under the Resident Behavior and Facility Practices due to the systemic failure to report, investigate and protect residents from further abuse. Findings include: 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	F 226	a. R 15 allegations were thoroughly investigated per policy. b. Residents educated during Resident Council on 6/27/2017 on their rights and responsibilities of being in a safe environment and their rights regarding the Abuse Prevention/Vulnerable Adult Plan. All residents were interviewed to ensure that they felt safe in the environment and all abuse allegations were investigated thoroughly. c. Policy and procedure for Abuse Prevention/Vulnerable Adult Plan policy reviewed and remains current. All staff were educated to the Abuse Prevention/Vulnerable Adult Plan. Education on completing a thorough investigation completed administrator, director of nursing, social services, and assistant director of nursing. d. Administrator or Designee will complete an audit with 3 random residents, via interview, to ensure they feel safe in the facility and abuse allegations are investigated timely and thoroughly. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations. a. R24□s fall was investigated and it was determined that the care plan was followed at the time of the fall. b. All falls were audited to ensure care plan was followed at the time of the fall. c. Policy and procedure for Assessing Falls and their Causes reviewed and remains up-to-date. Education to all licensed nursing staff on policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 24 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." The investigation would begin immediately, led by the investigation team. The investigation may include "interviewing staff, residents, or other witnesses to the incident" and "corrective action based on the investigation will be completed (e.g., change of procedure, training, discipline or discharge of staff, etc.)" R15's admission record dated 3/31/17, identified R15 had paraplegia, anxiety disorder, major depressive disorder, borderline personality disorder and sacral region pressure ulcers. R15's quarterly Minimum Data Set (MDS) dated 1/6/17, indicated R15 was cognitively intact, able to express ideas and wants both verbally and non-verbally, make herself understood, and was also able to understand others with clear comprehension. Further, the MDS identified R15 required extensive assistance of two staff for bed 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	F 226	overview of falls and ensuring care plan is followed at the time of a fall and procedure for notification if care plan is not being followed. d. Director of Nursing or designee complete an audit of a random selection of residents to ensuring care plan is followed at the time of a fall and procedure for notification if care plan is not being followed. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 25	F 226		

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 it went very quick from being loud to yelling. R15 stated she 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 you don't know how to spell."

R15 continued the interview and verbally identified and confirmed the nursing assistant in this altercation as NA-C, and also stated NA-B was in her room and witnessed the entire incident. R15 stated she had not turned in the grievance form to administration yet, because she was concerned about the sequencing of the events and wanted to ensure it was accurate. R15 stated during the altercation on 5/2/17, after NA-C left the room, NA-B verbally stated to her that, NA-C, "can get a lot worse, be careful." R15 presented the surveyor a form titled, Grievance, that was partially completed. R15 stated she began filling it out on 5/2/17, after the altercation but wanted to make sure it was detailed enough.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 26	F 226		

R15 stated she kept thinking about the altercation in her head and, "I just messed up." R15 then paused and stated, "How can I report if I don't get it exactly right." In additional R15 identified she was afraid of retaliation that she may be given a discharge notice if she complained.

R15 stated since the altercation occurred on 5/2/17, no other staff, including the DON, licensed social worker (LSW), or administrator, had come to talk to her about the altercation on 5/2/17, between herself and NA-C. R15 stated the altercation with NA-C "made me feel terrible." R15 stated she had overheard several other staff members talking about the altercation on 5/2/17, which she emphasized this had upset and bothered her as well. Adding, after the altercation LPN-A told her NA-C had a "bad temper." Further, R15 stated she felt, "no one is ever held accountable," at the facility and she questioned if, "anyone would do anything," about her grievance if she completed the form and had turned it in. R15 added the administration had attempted to discharge her from the facility in 2/17, while she was hospitalized. R15 stated she continued to be upset by this, as she had not come to terms with the attempt at discharge. R15 stated she got the Ombudsman involved, who assisted in filing the appeal for the facility's "emergency discharge" action, and the discharge was rescinded.

When interviewed on 5/30/17, at 3:49 p.m. NA-B stated she recalled the altercation between NA-C and R15 which happened on 5/2/17. NA-B stated NA-C and R15 had argued about her turning and repositioning when R15 accused NA-C of "yelling" at her. NA-B stated they were, "stating a fact." NA-B stated NA-C tried repeatedly to verbally make her point, and walked out of the room to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 27	F 226		

regroup. NA-B stated she reported the event to a nurse, but was unable to remember who the nurse was when questioned.

When interviewed on 5/30/17, at 4:03 p.m. NA-C stated she recalled the altercation she had with R15 on 5/2/17, and had reported it to the nurse working on the same night. NA-C stated after the incident she also reported the altercation to the DON, but could not recall the day and/or time she reported it. NA-C stated R15 had argued with her and NA-B about repositioning. NA-C stated R15 did not believe them regarding the times R15 had been last repositioned. NA-C stated R15 verbally cussed at the aides and accused her of yelling. NA-C stated she was trying to give R15 an answer about her repositioning adding she told R15, "You're not taking my answer." Further, NA-C stated she provided R15 a grievance form to fill out with her name on the form before giving it to the resident because "my last name is difficult to spell." NA-C at this time also stated R15 called her a "fucking bitch." NA-C also acknowledged and stated she told R15 she could be a "bitch, but was trying not to be."

During a subsequent interview on 5/31/17, at 4:07 p.m. R15 again explained the altercation that occurred when R15 alleged abuse by facility staff. R15 stated the incident happened on 5/2/17, around 7:00 or 8:00 p.m., after the evening meal, and R15 repeated her concerns about the length of time she was lying in bed in the same position and the need for repositioning. R15 described the altercation as an argument with NA-C that went back and forth and escalated. When asked how R15 felt in NA-C's presence now, R15 stated, "nervous and afraid." R15 added she did not like how the incident on 5/2/17, made her feel,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 28	F 226		

and stated, "I felt threatened that night."

R15's progress note dated 5/2/17, authored by (RN)-A at 21:42 (9:42 p.m.) indicated, "NAR [nursing assistant registered] reported to writer that when staff member went to reposition resident, Resident began questioning NAR about repo [repositioning] scheduling. NAR explained to res [resident] that she had just began her shift and repositioned res when she arrived and now, at time of reporting to writer, prior to eve meal scheduling is on time. Res became argumentative with staff member. Staff member assured res that she on time. Res stated 'Why are you arguing with me, you don't have to yell.' Staff member stated, 'I was not yelling or mad, I only told you what I know.' Res replied 'Why are you yelling at me, you are a bitch!', staff member stated she was not angry or yelling. There was another staff member, NAR in the room as well. NAR reporting stated that she will allow res time to become calm and return as res was becoming increasingly agitated and calling Staff member a bitch. Writer went to res room a while after and res is sleeping."

R15's progress noted dated 5/4/17, at time authored by licensed practical nurse (LPN)-B indicated, "Resident will not allow [NA-C] into her room when it was time to repositioning."

Review of R15's progress notes from 5/2/17 to 5/31/17, lacked additional investigation and documentation of the altercation on 5/2/17, or any related follow up to this occurrence.

Facility staff schedules from 5/1/17 to 5/31/17 were reviewed, and indicated the following:
NA-C was scheduled on the following days:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 29	F 226		

5/2, 5/4, 5/6, 5/7, 5/8, 5/9, 5/13, 5/14, 5/16, 5/19, 5/22, 5/23, 5/25, 5/26, 5/30, and 5/31/17.

NA-B was scheduled on the following days: 5/2, 5/5, 5/6, 5/7, 5/10, 5/11, 5/12, 5/15, 5/16, 5/17, 5/18 5/19, 5/20, 5/24, 5/25, 5/26, and 5/30/17.

When interviewed on 5/31/17, at 5:02 p.m. the DON discussed the altercation which occurred on 5/2/17, between R15 and NA-C. The DON stated the first time she learned of the altercation between R15 and NA-C was "last Thursday" (5/25/17) when NA-C approached her. The DON stated no staff member had immediately called her. When surveyor reported R15 felt she was "emotionally abused" the DON reacted and stated that was the first "I have heard about this." The DON reviewed the progress notes and acknowledged she did not see any follow up with R15 since the incident, and also stated she did not have someone talk to the resident (R15). The DON stated that had she read the note, she would have talked to the nursing assistants and the resident, "This is what we used to do all the time." The DON added she was unaware NA-C allegedly signed, dated and handed R15 a grievance form about the incident. The DON stated had she known about this, she would have pulled NA-C off the floor, pending an investigation, and also would have talked to the resident. The DON stated, "Call me, I'm on call 24/7". The DON stated she talked to NA-C but did not take it further. She further stated somehow she missed the note.

During interview on 5/31/17, at 5:52 p.m. the administrator stated the incident had just been explained to him. The administrator stated R15 had a difficult time with staff, mentioning that R15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 30	F 226		

recently had a room change and had hard feelings toward him and the DON. In regard to R15's incident on 5/2/17, the administrator stated there might have been a verbal exchange between R15 and NA-C, and it was his understanding they had a disagreement. The administrator stated the DON had talked with NA-C, but, "I would have to talk to [R15] to get her side of the the story." The administrator stated they would put the staff person involved in the allegation on leave during the investigation and replace them, "to protect the other residents," during their investigation. The administrator also stated he would do immediate education regarding dignity, patience and resident rights.

During a subsequent interview on 5/31/17, at 8:02 p.m. the administrator stated he had just visited with NA-C and suspended her because he just talked with R15, who told me "this staff member made me feel threatened." The administrator stated we would "make things right for [R15]."

When interviewed to ensure the IJ removal plan had been implemented on 6/2/17, at 10:43 a.m. LPN-C stated staff was required to complete routine training on various topics, including vulnerable adults and abuse prevention, however, she had not completed it yet for the year. LPN-C stated she had not received any training in the past few days regarding identification of potential abuse, timely reporting of it or how to handle resident allegations of abuse. LPN-C stated if she witnessed or suspected an altercation between staff and a resident and it had potential to be verbal abuse, she would visit with the resident involved and report the situation to the charge nurse or administration. LPN-C stated she was not trained in, nor sure how to handle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 31	F 226		

any staff person involved in a potential altercation as she tried to avoid, "words with the aides." LPN-C stated she had noticed staff interacting with residents before and, "the tone in itself isn't always the nicest," further adding, "The tone around here in general, by staff, is not always the nicest." LPN-C stated she would not immediately remove or suspend a staff member who had allegations of potential abuse made against them as she, "wouldn't feel authorized to do that," and further added the staff, "probably wouldn't listen to me anyway." Further, LPN-C stated she had reported concerns about the tone of staff, "in the past," to the DON and social worker.

A message was left for registered nurse (RN)-A during the survey on 6/1/17, at 1:15 p.m. who did not respond to a telephone call. During a telephone interview on 6/5/17, at 1:16 p.m. RN-A stated she worked with R15 on 5/2/17, and following the altercation, checked on R15 but R15 was sleeping. RN-A stated she checked back and asked R15 what 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 emotional or verbal abuse, however, stated the resident felt safe. RN-A stated she did not document the second conversation she had with R15, and this behavior was typical for R15. RN-A stated [NA-C] "was a favorite" for R15 up until then. RN-A stated she took no further actions, and did not feel any need to call the administrator or DON about this incident.

Although the facility acknowledged the altercation between R15 and NA-C on 5/2/17, the facility's inaction to fully identify R15's potential abuse that day and subsequently, or take steps to ensure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 32	F 226		

safety of R15 immediately pending any finding, or thoroughly investigate the circumstances to make a determination. There was no investigation completed to determine possible abuse, nor did the facility protect other residents as identified by the facility policy.

The facility Abuse Prevention/Vulnerable Adult Plan dated 4/17, directed that incidents reported to the state agency included, not following a resident care plan.

R24's annual MDS dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfer and ambulation. The MDS 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 care plan revised on 3/8/17, identified R24 had a potential for falls/accidents. Risk factors included use of medications, pain, a fall 6/14, resulting in an intracranial hemorrhage, resulting in impaired mobility/cognition, impulsivity, and placing him at higher risk for falls. The care plan identified R24 had fallen several more times since the initial fall. A fall mat at the resident's bedside was listed as an intervention. R24's undated Group D nursing assistant sheet identified a floor mat as a safety intervention for R24.

A progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off at 1:20 a.m. and staff found him lying on his stomach "on the floor" in a pool of blood. The blood was coming from a laceration on his head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 33	F 226		

R24's emergency room discharge report 5/11/17, indicated the resident received seven sutures to a head laceration.

During observation on 5/31/17, at 7:37 p.m. R24 was lying in bed without a fall mat on the floor by 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 to help another resident. No floor mat was put by R24's bedside.

During interview on 5/31/17, at 8:06 p.m. trained medication aid (TMA)-A stated R24 needed to have a fall mat at his bedside.

During interview on 6/2/17, at 10:33 a.m. the DON reviewed the progress note regarding the the fall dated 5/11/17, and stated it did not look as if the fall mat was on the floor at the time of the fall as care planned. The DON further stated she did not realize until 6/2/17, while reviewing the progress note the resident was found on the floor and not his fall mat. The DON proceeded to look for the fall investigation and stated it had not completed and there were no further details regarding the fall on 5/11/17. The DON stated when reviewing falls and implementing new interventions the fall investigation sheet was not always reviewed, and this was why she did not know the investigation had not been completed. The DON stated the assessed fall interventions prior to the fall were expected to be followed and if the staff were not following the care plan on 5/11/17, the fall should have been reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 34 state agency and thoroughly investigated, per the facility policy.	F 226		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hearing devices were consistently offered and audiology was consulted for a change in hearing ability for 1 of 1 residents (R44) who complained about difficulty with hearing. Findings include: R44's annual Minimum Data Set (MDS) dated 4/26/17, identified R44 had moderate cognitive impairment. Further, the MDS identified R44 had, "Minimal difficulty," with hearing and did not use hearing aides. During interview on 5/30/17, at 11:13 a.m. R44 stated he wanted to, "Find out more about my hearing problems." R44 stated he wanted to get hearing aides but didn't know how. R44 stated his hearing was, "kinda getting bad," and he was having to "strain more," with his hearing. R44 did not have hearing aides in place during the	F 246	F 246 a. R 44 was referred to an audiologist. Nursing care guides were updated to reflect need for hearing aids. b. Audit of all residents that have hearing aids to ensure proper fit and functionality was completed and referrals made as appropriate. Care delivery guides have been updated to reflect need for hearing aids. c. Education of nursing staff on reporting changes in hearing to the charge nurse and following care guides. d. Social Services or designee will complete an audit of 5 residents noted to have hearing difficulties to ensure needs are met regarding audiology consultation. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 35	F 246		

interview.

During subsequent observation on 5/31/17, at 12:52 p.m. R44 was seated in his wheelchair in the hallway. R44 did not have hearing aides in place.

A recent mental health Progress Note dated 3/31/17, identified R44 had been seen for a mood disorder due to a past stroke. The provider visited with R44 and documented, "For most of the questions I asked him, he stated 'I can't hear you.'" The note was unsigned by nursing home staff, and lacked any evidence hearing issue had been reviewed.

When interviewed on 5/31/17, at 7:48 p.m. nursing assistant (NA)-E stated R44 was hard of hearing and, "deaf" in at least one ear. NA-E stated she had never seen R44 wear hearing aides, and did not use them to her knowledge. Further, NA-E stated R44's hearing seemed, "a little worse," in the past months and this had been reported to the nurses, "I believe the nurses are aware of it."

During interview on 6/1/17, at 11:46 a.m. licensed practical nurse (LPN)-A stated R44, "Sometimes," has hearing issues, but did not wear any hearing aides to her knowledge. LPN-A stated she was unaware the NA staff had noticed R44's hearing to be worsening in the past months. LPN-A stated if a resident used hearing aides, they were kept in the medication carts so they are not lost. LPN-A reviewed the medication cart and was unable to locate any hearing aides for R44. Further, LPN-A stated the NA staff should be reporting changes with hearing as, "maybe he needs to see audiology."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 36	F 246		

R44's Referral/Clinic Form dated 2/19/16, identified R44 had been seen by the physician and identified to have, "asymmetrical hearing loss." The physician provided orders, "May go to audiology for hearing aids [sic]." This was completed on 3/15/16, with no further consults being identified in his medical record.

R44's medical record lacked any evidence R44's worsening hearing had been reported to the physician or referred to audiology for further testing.

When interviewed on 6/1/17, at 12:27 p.m. the assistant director of nursing (ADON) stated R44 had a history of being, "Hard of hearing," with his last hearing appointment being completed, "not that long ago." ADON stated R44 used to have a hearing aide, however, was having behaviors with it. The ADON stated she was unsure where the hearing aide went, but would look for it.

R44's care plan dated 6/18/15, identified R44 was at risk for impaired communication with impaired vision and hearing. The care plan directed staff to, "Ensure placement of hearing aids as needed," and to provide, "Hearing and/or Vision Consultation as needed." The care plan lacked any identified behaviors regarding his hearing aides.

During subsequent interview on 6/1/17, at 1:16 p.m. ADON stated she found R44's hearing aide in the medication room, but was unsure who had removed it from the medication cart and placed it there. ADON stated she had just spoken with R44 who responded to her with, "I can't hear you," but declined to use the hearing aide when offered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 37 ADON stated staff were still expected to attempt to offer R44 the hearing aide despite his past behaviors adding, "We need to try." ADON stated the nurses used to have a treatment ordered to ensure this happened, however, it had been accidentally removed when the facility ownership changed and was not carried over. Further, ADON stated if NA staff had noticed worsening hearing, it should have been addressed and a referral made to the audiologist to, "see if there's any changes." A facility policy on coordination of care with audiology services was requested, but none was provided.	F 246		
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R22) reviewed for admission, transfer and discharge practices was notified timely prior to a change in roommate. Findings include: R22's annual Minimum Data Set (MDS) dated 4/12/17, identified R22 had intact cognition.	F 247	F 247 a. R22 was given a roommate on 3/27/2017 and was introduced to roommate at the time roommate was moved into his room. b. Audit of all residents that received a new roommate in past 60 days completed to ensure room change notification has been given. c. Policy and procedure for	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 38 During interview on 5/30/17, at 11:33 a.m. R22 stated he had a roommate change within the past several months and was not notified prior, "[Staff] just bring them in." R22 stated he would have liked to have some notice of a new roommate coming before they 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. R22's medical record was reviewed and lacked any documentation to demonstrate R22 had been informed of the new roommate prior to their arrival in the facility. When interviewed on 6/1/17, at 8:54 a.m. licensed social worker (LSW)-A stated the facility used, "Room change forms" to alert residents when they are getting a roommate; however, LSW-A stated she was unable to locate this for R22's recent roommate change in 3/17. LSW-A stated she spoke with the corporate consultant staff and the documented note of him being upset, "shows he was informed he was getting one." Further, LSW-A stated the facility had no way to demonstrate R22 was told prior to the new roommate arriving, but he should have been given as much warning as possible to, "make sure he had time to calm down and adjust to it." An undated facility policy, Room or Roommate Change, identified a, "Room or roommate	F 247	Room/Roommate change policy reviewed and remains current. Social services educated regarding Room/Roommate change policy. d. Administrator or designee to complete an audit of all residents that received a new roommate for proper notification. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 247		
F 258 SS=D	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. Findings include: R12's significant change Minimum Data Set (MDS) dated 5/2/17, indicated R12 had severe cognitive impairment, was sometimes able to make himself understood and responded adequately to simple, direct communication only. The MDS indicated R12 had highly impaired hearing. R16's significant change MDS dated 5/10/17, indicated R16 had severe cognitive impairment, sometimes was able to make self-understood and responded adequately to simple, direct communication only. The MDS indicated R16 had adequate hearing.	F 258	F 258 a. The air mattress pump was exchanged for a properly functioning pump for R 12 and malfunctioning 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 proper comfortable, sound level is maintained. c. All staff will be educated on notification to maintenance director on any 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 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.	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 40	F 258		

During observation on 5/30/17, at 2:17 p.m. R12 was sleeping on a Micro Air 65 alternating air mattress. The mattress turned on and created a loud vibrating rumbling sound as it rattled against the bed. The noise was so loud a conversational level voice, would not be possible to hear. R12 opened her eyes when the air mattress started then closed her eyes again.

During observation on 6/1/17, at 2:22 p.m. R12 was sleeping on her air mattress when the air mattress turned on again making a loud vibrating rumbling sound as it rattled against the bed. The noise was so loud a conversational level voice would not be possible to hear. The air mattress motor was hanging at the foot of the bed and had white wash clothes under the hooks between the motor and footrest of the bed.

During interview on 6/1/17, at 2:23 p.m. nursing assistant (NA)-H stated she was not sure how R12 or R16 slept in the room when the air mattress turned on. NA-H further stated "I couldn't sleep through that noise." NA-H stated she was unsure if the noise from the air mattress had been reported.

During interview on 6/1/17, at 2:24 p.m. NA-J stated the air mattress was noisy and had been that way for about two to three months. NA-J said it had been reported originally two to three months ago and the facility had tried to fix it, but it was still really loud. NA-J stated the washcloths between the motor of the air mattress and footboard were there to try and decrease the noise. NA-J stated R16's family member had asked one day what that noise was when she was visiting R16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 258	Continued From page 41 During the environmental tour on 6/1/17, at 2:31 p.m. the environmental services director (ESD) and the administrator were present. The ESD stated the washcloths had been placed to decrease the vibration and the noise. The ESD also stated a board had been placed at the base of the wall to keep the bed away from the wall, to help with the noise. The administrator stated R16 and R12 could not complain of the noise due to their cognitive abilities but R16's family member had mentioned a loud noise coming from R12's bed some time back. The administrator stated the air mattress was too loud and they would get the mattress switched out. A policy on monitoring noise was requested, but none was provided.	F 258		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop an initial care plan for skin integrity issues for 1 of 3 residents (R18) reviewed for pressure ulcers. Findings include: R18's Admission Record indicated R18 admitted to the facility on 3/15/17. R18's diagnoses	F 281	F 281 a. R18 was discharged from the facility on 3/31/2017. b. All new admissions, since survey exit, will be reviewed to ensure proper care plan initiation and interventions to prevent pressure ulcers on those identified at risk. c. Nursing Management Team will be	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 42 included fracture to neck of right femur, idiopathic peripheral autonomic neuropathy and reduced mobility. R18's Admit/Initial Data Collection dated 3/15/17, indicated 18 separate skin impairment sites as follows: right antecubital, left antecubital, right elbow, left elbow, right thigh front, left thigh front, left knee front, right knee rear, right lower leg front, left lower leg front, right lower leg rear, left lower leg rear, right ankle inner, left ankle inner listed twice, right ankle outer listed twice, and left ankle outer. The assessment did not identify the type of skin issue and lacked any measurements/description. R18's undated Initial Care Plan (temporary care plan) for skin integrity did not identify any interventions to minimize risk for pressure ulcers. During interview on 6/2/17, at 8:23 a.m. licensed practical nurse (LPN)-C stated the floor nurse admitting the resident was responsible to fill out all areas of the temporary care plan. During interview on 6/2/17, at 9:20 a.m. registered nurse (RN)-A looked at the initial care plan and stated the skin risk area did not have any interventions. RN-A stated the floor nurses were responsible for completing the temporary care plan. During interview on 6/2/17, at 9:41 a.m. RN-B stated the initial care plan needed to be completed within 24 hours of admission and should have included a skin integrity plan with interventions to prevent pressure ulcers. During interview on 6/2/17, at 10:24 a.m. the	F 281	re-educated on the development of an initial care plan including skin integrity issues. d. Director of Nursing or designee will review a random sample of new admissions for development of initial care plans. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 43 director of nursing (DON) stated she had identified assessments and care plans for skin were an issue and had started re-training staff the previous week. The DON further stated she expected staff to complete temporary care plans. A policy on temporary care plans was requested and not received.	F 281		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care planned interventions to prevent injury for 1 of 2 residents (R24) reviewed for falls, and 2 of 2 residents (R75, R27) reviewed for safety with smoking and/or wandering. Further, the facility failed to follow the plan of care for wound monitoring for 1 of 3 residents (R44) reviewed for pressure ulcers. Findings include: R24's annual Minimum Data Set (MDS) dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified diagnoses of hypertension, arthritis, dementia and anxiety. The MDS identified R24 needed extensive assistance	F 282	F 282 a. R 24 care plan was reviewed and updated appropriately for falls. R 75 care plan reviewed to reflect proper Wanderguard use and smoking safety. R 27 care plan was reviewed and updated appropriately for smoking safety. R 44 care plan was reviewed and updated appropriately for pressure ulcer management. b. Residents who have had a new fall since survey exit will be reviewed thoroughly to ensure immediate interventions are placed at the time of a fall to prevent injury and care plans updated with immediate interventions. All	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 44 for bed mobility, transfers, and ambulation and indicated R24 had two or more falls without injury since the last assessment dated 1/25/17. R24's care plan revised on 3/8/17, indicated a potential for falls/ accidents. Risk factors included use of medications, pain, a fall in 6/14, which resulted in intracranial hemorrhage with impaired mobility, impulsivity and cognition which placed him at higher risk for falls. The care plan indicated R24 had fallen several more times since the initial fall. A fall matt at the bedside was listed as a fall intervention. R24's undated Group D nursing assistant sheet included a fall mat. A progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off at 1:20 a.m. and staff found him lying on his stomach "on the floor" in a pool of blood. The blood was coming 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. During interview on 5/31/17, at 7:56 p.m. nursing assistant NA-H stated the fall matt was not on the floor as directed. NA-H looked for the fall matt and could not find it. NA-H left the room and went to help another resident. 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.	F 282	residents that utilize a Wanderguard will be reviewed to ensure Wanderguard□s are placed and functioning. Care plans updated as indicated. All residents that smoke will be reviewed to ensure proper safety measures are implemented to prevent injury. All residents who have current pressure ulcers will be audited to ensure weekly wound monitoring is completed. c. Policy and procedure for Falls □ Clinical Protocol, Code Alert Wandering Monitor System, Resident Smoking, and Weekly Charting Wound Ulcer Documentation reviewed and remain current. Education to nursing staff on appropriate policies, and ensuring proper procedures and interventions are utilized per care delivery guides. Falls training with all licensed nurses on reviewing the care plan, and determination that care plan is followed at the time of a fall. Education to licensed nursing staff on proper monitoring of pressure ulcers. d. Director of Nursing or designee complete an audit of a random selection of resident□s that fell for the care plan being followed. Social Services or designee will complete an audit of 3 residents that utilize a Wanderguard for ensuring care plan is being followed. Social Services or designee will complete an audit of all resident□s that smoke to ensure proper interventions are in place and care plan is being followed. Director of Nursing or designee will complete an audit to ensure weekly monitoring of all pressure ulcers is completed per care plan. Audits will occur weekly times 4,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 45 During interview on 6/2/17, at 10:33 a.m. the director of nursing (DON) stated, based on the information charted on the fall dated 5/11/17, it didn't sound as if the fall matt was on the floor. The DON further stated assessed fall interventions were expected to be followed. WANDERGUARD: R75's admission MDS dated 2/21/17, identified moderate cognitive impairment and wandering behavior which placed him at risk for getting to a potentially dangerous place. R75's care plan dated 2/15/17, indicated R75 was at risk for elopement related to attempts of leaving the facility and wandering. R75's goals were to have no incidence of elopement and to remain safe during placement at the facility. The care plan identified an intervention of, "Wanderguard placed." 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. When observed on 5/31/17, at 7:17 p.m. R75 was lying in his bed on top of the blankets, fully clothed. He was watching television. R75 did not have a Wanderguard on. The Wanderguard was located on his bedside table, however, the band on the Wanderguard was broken. During interview on 5/31/17, at 7:18 p.m. R75 stated he used to wear a Wanderguard on his wrist, but the band on the Wanderguard broke several weeks ago. R75 stated he told the staff the band had broken on the Wanderguard, but no one had fixed it or given him a new one. R75	F 282	monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 46	F 282		

stated sometimes he kept the Wanderguard in his pants pocket or his coat pocket, but not always.

When interviewed on 5/31/17, at 7:26 p.m. TMA-A stated R75 wore a Wanderguard. At 7:30 p.m. TMA-A went to R75's room and found the Wanderguard sitting on his bedside table. TMA-A stated R75 should have it attached to his body and not sitting on the bedside table.

When interviewed on 6/1/17, at 7:54 a.m. NA-K stated R75 was an elopement risk and wore a Wanderguard located on his wheelchair. During interview on 6/1/17, at 8:04 a.m. NA-J stated R75 did not wear a Wanderguard.

When interviewed on 6/1/17, at 12:18 p.m. the director of nursing (DON) stated she expected staff to follow a resident's care plan. The DON further stated, not having the Wanderguard attached to R75 was considered not following the care plan.

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 an admitting diagnosis of, "Tobacco Use."

R75's care plan dated 3/22/17, indicated "Resident currently smokes at this facility," and included a goal for R75 of, "Resident will smoke safely." The care plan listed interventions which included, "Independent with smoking per evaluation," and, "Smoking apron per evaluation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 47	F 282		

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 was smoking, but did not believe R75 needed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 48	F 282		

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 smoked per his 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 considered not following the care plan.
R27's admission Minimum Data Set (MDS) dated 4/3/17, identified moderate cognitive impairment and indicated R27 currently used tobacco products.

R27's care plan dated 4/20/17, identified R27 was currently smoking while at the nursing home. R27's care planned goal was, "Resident will smoke safely." Further, the care plan listed interventions including, "Use walker while going outside to smoke," and, "Smoking apron per evaluation."

R27's Smoking Evaluation Form dated 5/25/17, indicated R27 was able to smoke independently and listed, "Facility specific interventions including need for adaptive equipment," with a written, "X"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 49	F 282		

placed next to, "Smoking apron [device covering skin and clothes to prevent burns from dropped ashes]."

During observation on 5/30/17, at 1:34 p.m. R27 came to the nursing station and was provided a folded up gray colored smoking apron, lighter and three single cigarettes from licensed practical nurse (LPN)-E. R27 then ambulated outside using his walker. R27 placed the folded up smoking apron on the table outside and proceeded to light his cigarette(s) and smoke them. R27 stated the staff was aware he was not wearing the provided smoking apron but had, "never questioned it."

During interview on 6/1/17, at 8:52 a.m. nursing assistant (NA)-D stated R27 took the smoking apron outside with him and staff only assisted him with using it if he wanted it as, "That's up to him." NA-D stated use of the smoking apron was, "highly recommended" though, to reduce the risk of burns.

When interviewed on 6/1/17, at 12:16 p.m. the assistant director of nursing (ADON) stated care plans were used to, "make sure every resident is getting their independent needs met," and staff were expected to follow it. The ADON further stated R27 should be using the smoking apron as directed by his evaluation and care plan.

LACK OF ADEQUATE WOUND MONITORING:

R44's annual Minimum Data Set (MDS) dated 4/26/17, identified R44 had moderate cognitive impairment, required extensive assistance with activities of daily living (ADLs), had a current stage III (described as full thickness tissue loss)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 50	F 282		

pressure ulcer and remained at risk for pressure ulcer development.

R44's care plan dated 5/8/17, identified R44 had a pressure ulcer due to bowel and bladder incontinence and limited mobility. The care plan identified R44 had a current stage III pressure ulcer on his buttock and directed staff to complete, "Weekly wound assessment," and, "Conduct weekly skin inspection."

During observation on 6/2/17, at 9:57 a.m. licensed practical nurse (LPN)-C completed R44's dressing change. LPN-C stated she did not routinely measure the ulcer with dressing changes as, "that's only scheduled or whatever." LPN-C completed no measurements/data collection of R44's pressure ulcer.

When interviewed on 6/2/17, at 10:26 a.m. LPN-C stated she was unaware who was assigned or responsible to measure and document characteristics of pressure ulcers. LPN-C stated floor staff only measure the pressure ulcer if directed to do so by the treatment administration record (TAR).

R44's TAR dated 4/25/17, to 5/30/17, directed staff, "Complete Weekly wound evaluation [Monarch Health Management (MHM) Weekly Wound Evaluation] under forms tab for coccyx wound." This was scheduled to be completed on a weekly basis on 4/26/17, 5/3/17, 5/10/17, 5/17/17, 5/24/17 and 5/31/17. However, on 5/3/17, the entry was recorded as, "Absent from home," and on 5/10/17, the entry was recorded as, "Drug refused." Further, on 5/17/17, the entry was recorded as, "Other / See Nurses Notes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 51 R44's MHM Weekly Wound Evaluation dated 4/30/17, 5/1/17, 5/19/17, and 5/30/17 identified R44 had a stage III pressure ulcer on his coccyx. Additionally, the evaluations contained measurements of the stage III pressure ulcer. The evaluations further identified R44 visited a wound clinic. Although evaluations contained data, there was no comprehensive weekly wound assessment as directed by the plan of care. R44's medical record was reviewed. There was no additional documentation identified to demonstrate R44's pressure ulcer and associated characteristics had been monitored/assessed on a weekly basis as directed by the care plan and to ensure healing. When interviewed on 6/2/17, at 11:35 a.m. the director of nursing (DON) stated the floor nurses were responsible to measure and document R44's pressure ulcer on a weekly basis using the MHM Weekly Wound Evaluation form(s) in the electronic medical record. The DON reviewed R44's medical record and stated his pressure ulcer had not been tracked weekly, but should have been, "for continued monitoring to ensure the wound is healing," and R44's, "treatment [was] still effective." A facility policy on implementation of the care plan was requested, but none was provided.	F 282		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the	F 314		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 52 facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pressure ulcer risk, implement interventions and conduct weekly skin monitoring for 1 of 3 residents (R18), who developed multiple pressure ulcers after admission, resulting in actual harm. In addition, the facility failed to consistently monitor pressure ulcer characteristics for 1 of 3 residents (R44) reviewed who had a current pressure ulcer. Findings include: R18's Admission Record indicated R18 admitted to the facility on 3/15/17. R18's diagnoses included fracture to neck of right femur, idiopathic peripheral autonomic neuropathy and reduced mobility. R18 was discharged from the facility with home care on 3/31/17. R18's hospital discharge summary dated 3/15/17, indicated R18's skin was intact other than surgical wounds covered with dressings.	F 314	F 314 a. R 18 has been discharged from the facility on 3/31/2017. R 44 will have weekly wound evaluations completed. b. Audit of all new admissions since survey exit reviewed to ensure they are comprehensively assessed for pressure ulcer risk and interventions are implemented to prevent pressure ulcers. Additionally, an audit of weekly wound monitoring will be completed on all current residents with pressure ulcers for pressure ulcer characteristics. c. Policy and procedure for Weekly Charting Wound Ulcer Documentation reviewed and remains current. Nursing Management Team will be re-educated on comprehensively assessing for pressure ulcer risk and implementing appropriate interventions to prevent pressure ulcers. Licensed nursing staff will be educated on monitoring for interventions being followed to prevent pressure ulcers. Education for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 53 R18's Admit/Initial Data Collection dated 3/15/17, identified 18 separate skin impairment sites as follows: right antecubital, left antecubital, right elbow, left elbow, right thigh front, left thigh front, left knee front, right knee rear, right lower leg front, left lower leg front, right lower leg rear, left lower leg rear, right ankle inner, left ankle inner listed twice, right ankle outer listed twice, and left ankle outer. The assessment did not identify the type of skin impairment and lacked any measurements. The assessment did not address any area of concern to either of R18's heels. R18's Tissue Tolerance Observation (assessment to determine specific pressure to an area over the course of a specified time) dated 3/16/17, indicated a lying repositioning schedule of every two hours, however; the assessment did not determine R18's heel pressure as a post surgical resident. The observation did not include a sitting recommendation for repositioning. R18's Braden Scale (assessment to identify pressure ulcer risk) dated 3/20/17, was not completed, the assessment was blank. R18's undated Initial Care Plan (temporary care plan) for skin integrity did not include interventions to minimize pressure ulcer risk. The care plan for mobility/safety directed staff to assist with transfers, assist with bed mobility, and turn and reposition or reminders to offload every two hours and as needed. R18's admission Minimum Data Set (MDS) dated 3/22/17, did not identify R18's cognitive status. The MDS indicated R18 needed extensive assistance with bed mobility and transfers. The MDS identified R18 was at risk to develop	F 314	nursing assistants regarding the reporting of skin issues they observe during their routine daily cares of residents and following interventions to prevent pressure ulcers. Education to licensed nursing staff on ensuring proper monitoring of pressure ulcers. Director of Nursing or designee will complete a weekly wound evaluation on all pressure ulcers for pressure ulcer characteristics. d. Director of Nursing or designee will review a random sample of new admissions for a comprehensive assessment for pressure ulcer risk has been completed and interventions are implemented to prevent pressure ulcers. 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 weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 54	F 314		

pressure ulcers and currently did not have pressure ulcers. The MDS included pressure relieving interventions of a pressure reducing device in bed and a pressure reducing device in the chair. The MDS did not identify a turn and reposition schedule for R18. The MDS further identified use of a diuretic (medication to control fluid).

R18's pressure ulcer Care Area Assessment (CAA) dated 3/28/17, indicated R18 was at risk to develop pressure ulcers related to a need for extensive assistance with bed mobility and frequent bladder and bowel incontinence. R18 admitted to the facility with surgical incisions with staples to the right hip. R18 had no history of pressure ulcers and no current pressure ulcers. The CAA directed staff to refer to the admission skin assessment and weekly skin assessment. Interventions in place included a pressure reduction mattress and wheelchair cushion. Staff was to assist with turning and repositioning.

R18's Skin Evaluation dated 3/29/17, indicated a Stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on the right heel measuring 2 centimeters (cm) x 2 cm. Staff identified the area as a blister. The assessment also identified a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) to the left heel measuring 2 cm x 1 cm x 0.3 cm. The assessment did not include any further description of the pressure ulcers, interventions, physician notification or treatment initiated. There was no evidence a Skin Evaluation was completed the previous week on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 55	F 314		

3/22/17, as the treatment sheet directed, although 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. LPN-C stated a skin assessment form was required weekly and it was not acceptable to just initial off on the treatment sheet. LPN-C stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 56	F 314		

the treatment sheet was a reminder to complete the assessment. LPN-C further stated the Braden assessments were completed by the registered nurse who did the MDS assessment. LPN-C stated if a new pressure area was identified, a treatment would be initiated, along with notifying the physician, family and director of nursing. LPN-C stated the floor nurse admitting the resident was responsible to fill out all areas of the temporary care plan.

On 6/2/17, at 9:20 a.m. registered nurse (RN)-A looked at the initial care plan and stated the skin risk area did not have any interventions. RN-A then reviewed the 3/20/17, Braden assessment and stated it was blank and had not been completed. RN-A stated the floor nurses were responsible for completing the Braden along with the temporary care plan. RN-A stated when she has time she would assist the nurses with assessments. RN-A further stated the weekly skin assessments were to be documented on the form in the electronic medical record (EMR). RN-A reviewed the 3/29/17, skin assessment and stated it indicated R18 developed two Stage 2 pressure ulcers on her heels. RN-A stated the physician should have been updated along with the managers to ensure treatments were appropriate and the cause of the pressure ulcers could be investigated. RN-A stated she did not visually inspect R18's skin when completing the MDS and relied on nursing documentation in the electronic medical record to do her assessment.

On 6/2/17, at 9:41 a.m. RN-B stated she was not told R18 had developed two Stage 2 pressure ulcers on her heels. RN-B stated the initial care plan needed to be completed within 24 hours of admission and should have included a skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 57	F 314		

integrity plan with interventions to prevent pressure ulcers. RN-B stated the MDS nurse was responsible for completing the Braden assessment and the floor nurses were required to complete a full skin audit weekly and document the findings on a form. RN-B further stated the MDS nurse should have noticed the assessments were not completed when doing the MDS assessments and should have told a supervisor.

During interview on 6/2/17, at 10:24 a.m. the director of nursing (DON) stated she had identified assessments and care plans for skin were an issue and had started re training staff the previous week. The DON further stated her expectations were timely and complete assessments along with completed temporary care plans. DON stated R18 developing two Stage 2 pressures ulcers after admission was a "concern."

On 6/2/17, at 11:31 a.m. a telephone message was left for R18's physician. On 6/5/17, at 1:38 p.m., via telephone, R18's physician stated R18 did not have pressure ulcers upon admission to the facility and she was not made aware R18 had developed two Stage 2 pressure ulcers after admission. The physician stated she expected the facility to implement interventions to prevent pressure ulcer and would expect to be notified when a resident developed pressure ulcers in order to provide appropriate treatment. This resulted in actual harm for R18.

Although, the facility implemented a pressure reducing mattress and cushion when R18 admitted to the facility on 3/15/17, following a right hip fracture. The facility failed to comprehensively assess and address R18's risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 58	F 314		

of pressure ulcer development on her heels, implement interventions to prevent pressure ulcer development, and monitor R18's skin on a weekly basis. As a result, R18 developed two Stage 2 pressures ulcers on their bilateral heels, 14 days following admission to the nursing home which resulted in actual harm for R18.

The undated facility Wound Process Checklist directed staff to "1. Notify MD/Treatment as ordered. 2. Notified family and/or responsible party. 3. Education completed with resident and family/ responsible party including review of risks and benefits. 4. Start weekly wound documentation form. 5. Notify nurse manager/ wound nurse. 6. Complete new tissue tolerance audit. 7. Complete new tissue tolerance evaluation. 8. Refer to dietary. 9. Refer to therapies. 10. Refer to interdisciplinary team members as appropriate. 11. Update care plan 12. Update nursing assignment care list. 13. Communicate in report."

R44's annual Minimum Data Set (MDS) dated 4/26/17, identified R44 had moderate cognitive impairment, required extensive assistance with activities of daily living (ADLs), had a current stage III (described as full thickness tissue loss) pressure ulcer and remained at risk for pressure ulcer development.

R44's care plan dated 5/8/17, identified R44 had a pressure ulcer due to bowel and bladder incontinence and limited mobility. The care plan identified R44 had a current stage III pressure ulcer on his buttock and directed staff to complete, "Weekly wound assessment," and, "Conduct weekly skin inspection."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 59	F 314		

During observation on 6/2/17, at 9:57 a.m. licensed practical nurse (LPN)-C set up supplies in R44's room to change his pressure ulcer dressing. R44 was in bed on an air mattress, positioned on his left side. LPN-C removed a foam dressing from R44's coccyx exposing a visible pressure ulcer. The removed dressing had no visible drainage present. R44's pressure ulcer appeared to be approximately 2 cm (centimeters) by 1 cm in size. The wound lacked any odor. LPN-C stated she did not routinely measure the ulcer with dressing changes as, "That's only scheduled or whatever." LPN-C sprayed R44's wound using a saline wound cleanser; however, R44 became resistive to the procedure and the dressing change was ceased. LPN-C completed no measurements of R44's pressure ulcer.

When interviewed on 6/2/17, at 10:26 a.m. LPN-C stated she was unaware who was assigned or responsible to measure and document characteristics of pressure ulcers. LPN-C stated floor staff only measure the pressure ulcer if directed to by the treatment administration record (TAR). Further, LPN-C stated R44's pressure ulcer, "Looked pretty good," today compared to when she last observed it.

R44's Treatment Administration Record (TAR) dated 4/25/17, to 5/30/17, directed staff, "Complete Weekly wound evaluation [Monarch Health Management (MHM) Weekly Wound Evaluation] under forms tab for coccyx wound." This was scheduled to be completed on a weekly basis on 4/26/17, 5/3/17, 5/10/17, 5/17/17, 5/24/17 and 5/31/17. However, on 5/3/17, the entry was recorded as, "Absent from home," and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 60	F 314		

on 5/10/17, the entry was recorded as, "Drug refused." Further, on 5/17/17, the entry was recorded as, "Other / See Nurses Notes."

R44's MHM Weekly Wound Evaluation dated 4/30/17, identified R44 had a stage III pressure ulcer on his coccyx. The ulcer was measured as 2 cm (centimeters; length) X (by) 0.1 cm (width) X 0.3 cm (depth) in size with 100% granulation tissue (red tissue indicative of healing) in the wound bed. The ulcer had no drainage or odor present. Further, the evaluation included a section labeled, "Summary," with, "No new changes. Continues to go to wound clinic every 2 weeks."

R44's MHM Weekly Wound Evaluation dated 5/1/17, (one day after previous evaluation), identified R44 had a stage III pressure ulcer on his coccyx. The ulcer was measured as 2 cm (length) X 0.2 cm (width) X 0.3 cm (depth) in size with 100% granulation tissue (red tissue indicative of healing) in the wound bed. The ulcer was identified to have, "Scant" drainage now present with no odor present. Further, the evaluation again included a section labeled, "Summary," with, "NA [not applicable] - Does go to wound clinic 5/3/17."

R44's subsequent MHM Weekly Wound Evaluation dated 5/19/17, (18 days after last evaluation), identified R44 now had an, "Unstageable [known wound but unable to visualize the wound bed]" ulcer on his coccyx. The ulcer was measured as 2.3 cm (length) X 0.3 cm (width) X 0.4 cm (depth) in size. A, "Further description of the wound," section was left blank with no amount of or type of drainage being selected, along with no dictation of any odor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 61	F 314		

being selected. The only selected option was, "Wound Edges," which were identified as, "Intact." Further, the evaluation again included a section labeled, "Summary," however, this section was left blank.

R44's most recent MHM Weekly Wound Evaluation dated 5/30/17, (10 days after previous evaluation), identified R44 had a stage III pressure ulcer on his coccyx. The ulcer was measured as 1.8 cm (length) X 0.3 cm (width) X 0.4 cm (depth) in size with 50% granulation tissue and 25% slough (dead tissue typically white or yellow in color) in the wound bed. The ulcer was identified to have no drainage or odor present. Further, the section labeled, "Summary," identified, "No changes to care plan at this time. Wound has had some improvement."

R44's medical record was reviewed. There was no additional documentation identified to demonstrate R44's pressure ulcer and associated characteristics had been consistently monitored on a routine basis to ensure appropriate monitoring for healing and need for treatment/intervention changes.

R44's Ridgeview Medical Center Wound & Hyperbaric Healing Center sheets identified he had been seen for treatment and evaluation of his pressure ulcer on 4/19/17, 5/3/17, and 5/17/17. However, none of the provided notes from the center identified any measurements or characteristics of the wound. The most recent visit on 5/17/17, only identified the pressure ulcer to be, "Sl [slightly] less deep," and provided dressing change orders.

When interviewed on 6/2/17, at 11:35 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 62 director of nursing (DON) stated the floor nurses were responsible to measure and document R44's pressure ulcer on a weekly basis using the MHM Weekly Wound Evaluation form(s) in the electronic medical record. The DON reviewed R44's medical record and stated his pressure ulcer had not been tracked weekly, but should have been, "for continued monitoring to ensure the wound is healing," and R44's, "Treatment [was] still effective." A facility Weekly Charting Wound Ulcer Documentation policy dated 9/11, identified a purpose which included, " ...the following components should be a part of your weekly [underlined] charting," and listed several components including the stage of the pressure ulcer, dimensions of the ulcer, and if undermining and/or tunneling is present.	F 314		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 63 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document 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: FALLS: 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.	F 323	F 323 a. R 24 care plan was reviewed and updated appropriately for falls. R 75 care plan reviewed to reflect proper Wanderguard use and smoking safety. R 27 care plan was reviewed and updated appropriately for smoking safety. b. Residents who have had a new fall since survey exit will be reviewed thoroughly for comprehensively assessing for root cause of the fall, immediate interventions placed at the time of a fall, and care plans updated with immediate interventions to prevent recurrent falls and injury. All residents that utilize a Wanderguard will be reviewed to ensure Wanderguard□s are placed and functioning for resident safety. All residents that smoke will be reviewed to ensure proper safety measures are implemented to prevent injury. Care plans updated as indicated. c. Policy and procedure for Falls □ Clinical Protocol, Code Alert Wandering Monitor System, and Resident Smoking reviewed and remain current. Education to nursing staff on appropriate policies,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 64 R24's fall Care Area Assessment (CAA) dated 4/28/17, identified R24 was at risk for falls due to being unsteady and not able to stabilize himself 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 months and indicated R24 was a moderate risk for falls. R24's care plan revised on 3/8/17, identified R24 had a potential for falls/ accidents. Risk factors included the use of medications, pain, a fall in 6/14, which resulted in an intracranial hemorrhage, resulting in impaired mobility/cognition, impulsivity, and placing him at higher risk for falls. The care plan identified R24 had fallen several more times since the initial fall. Interventions included: bed in low position, fall mat on floor bedside, mobility monitors on R24's bed and chair, ensure they are on and working, anticipate needs, provide rest periods, keep call light within reach when in room, keep environment free of clutter, monitor vital signs weekly, and monitor for medication side effects. R24's undated Group D nursing assistant sheet indicated safety interventions for R24 were low bed, floor mat and sensor alarm. R24's progress note dated 3/3/17, at 3:00 a.m.	F 323	and ensuring proper procedures and interventions are utilized per care delivery guides to prevent injury. Falls training with all licensed nurses on comprehensively assessing for the root cause of the fall, immediate interventions placed at the time of a fall, and care plans updated with immediate interventions to prevent recurrent falls and injury. d. Director of Nursing or designee complete an audit of a random selection of resident□s that fell for comprehensively assessing for root cause of the fall, immediate interventions placed at the time of a fall, and care plans updated with immediate interventions to prevent recurrent falls and injury. Social Services or designee will complete an audit of 3 residents that utilize a Wanderguard for ensuring care plan is being followed to prevent injury. Social Services or designee will complete an audit of all resident□s that smoke to ensure proper interventions are in place and care plan is being followed to prevent injury. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 65	F 323		

indicated R24's alarm was going off down the South Hall by the scale. R24 was found on his left side with a skin tear to the top of the left hand and a pink area to the left forehead. The Minnesota Incident Report dated 3/3/17, at 3:00 a.m. identified a possible cause of the fall was anxiety as the resident was propelling himself constantly. No interventions for R24 were listed on the form. The Fall Scene Investigation dated 3/3/17, at 3:20 a.m. identified R24 was last seen at 2:45 a.m., however, the areas for last time toileted, positioned, and offered fluids was blank on the form. The Post Fall Investigation/ Plan signed 3/6/17, indicated R24 was last toileted at 12:45 a.m. and an intervention added for staff to fold the scale when not in use. The rest of the form was blank. Although an intervention of folding the scale was implemented, it did not address R24's anxiety or initiate an intervention related to R24's anxiety.

R24's progress note dated 5/4/17, at 2:00 a.m. indicated R24 had a fall from from his bed and was found lying on his right side on his "floor mat" between his night stand and his bed. R24 received an injury of two skin tears. The right elbow skin tear measured 2 centimeters (cm) x 0.5 cm. The right shoulder skin tear measured 3 cm x 0.5 cm. The fall investigation dated 5/3/17, indicated R24 had no environmental factors, no predisposing physiological factors, had dementia, and ambulating/transferring without assist with improper/no footwear. No predisposing factors were identified. Immediate action taken was first aid to the skin tears and due to the resident's continued restlessness, staff assisted him to his wheelchair. The Incident Review and Analysis dated 5/5/17, identified potential causative factors as "unknown." Interventions added were to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 66	F 323		

remove the over the bed table, and move the night stand away from the bed. Although interventions were added to reduce the chance of injury, it did not address a potential cause or an intervention to minimize the risk of a subsequent fall.

R24's progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off in R24's room at 1:20 a.m. Staff found R24 lying on his stomach "on the floor" in a pool of blood, coming from a head laceration. R24 left with the paramedics at 1:55 a.m. There was no fall investigation. The Incident Review and Analysis dated 5/15/17, identified potential causative factors as resident attempting to get out of bed, unable to state why, but suspect toileting needs. Intervention added was to toilet on first night rounds. R24's 5/11/17, emergency room discharge report indicated he received seven sutures to a head laceration from his fall. This fall was similar to the fall on 5/3/17, however, the progress note did not indicate R24 was found on his fall mat or if the fall mat was in place at the time of the fall. There was no investigation completed to determine the details of the fall and minimize potential risk of further falls.

During observation on 5/30/17, at 2:34 p.m. R24 was seated in his wheelchair wearing yellow Crocs sandals that did not have a strap behind the ankle.

During observation on 5/31/17, at 7:37 p.m. R24 was lying in bed without a fall mat on the floor by the bedside. A pair of faded yellow Crocs sandals were on the floor. The bottom of the sandals were worn, as there was little tread remaining on the bottom of either sandal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 67	F 323		

During interview on 5/31/17, at 7:56 p.m. nursing assistant (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 stated the only shoes R24 wore were the yellow Crocs sandals. NA-H also stated that when R24 was propelling his wheelchair with his feet his Crocs sandals often fell off. NA-H then left the room and went to help another resident. No floor mat was put by R24's bedside.

During interview on 5/31/17, at 8:06 p.m. trained medication aid (TMA)-A stated a fall mat was to be on the floor next to R24's bed. TMA-A stated the fall mat was not at the bedside on the floor. TMA-A found the fall mat behind R24's door and placed it on the floor near R24's bed. TMA-A observed R24's sandals and stated they were worn. TMA-A further stated, "I don't like them [Crocs sandals], dumbest thing for an elderly man to wear."

During interview on 6/1/17, at 1:12 p.m. licensed practical nurse (LPN)-A stated an intervention is initiated right away following a fall "if we know the source" of the fall. LPN-A stated there was not a falls committee to her knowledge, but falls were reviewed at stand up meetings Monday through Friday. LPN-A stated R24 usually had gripper socks on or the yellow Crocs sandals. LPN-A observed the Crocs sandals and stated there was no tread on the bottom of the sandals, "I think we need to take those away, I'm going to take those out." LPN-A then removed the sandals from R24's room.

During observation on 6/1/17, at 2:52 p.m. the scale at the end of the South hallway was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	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 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 up meeting on business days, but stated the IDT is struggling with consistency of meetings at this	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 69	F 323		

time.

During interview on 6/2/17, at 9:37 a.m. NA-D stated the scale at the end of the South Hall was supposed to be folded up when not in use. NA-D also stated it was left in the down position most of the time.

During interview on 6/2/17, at 10:33 a.m. the director of nursing (DON) stated the fall process had changed since switching management companies a few months ago. When a resident falls the nurse is supposed to document the fall in the progress notes and fill out an investigation form in risk management. The DON stated the nurses should be putting an immediate intervention into place to try and prevent further falls and not just assessing and treating the immediate injuries. DON stated the IDT review had been "bumpy" and had not consistently been reviewing falls the following business day. DON stated she completed the Incident Review and Analysis following the IDT review of the fall. DON stated R24's fall on 5/3/17, happened on a Wednesday and the IDT did not review the incident until 5/5/17, on a Friday and stated a potential cause was not identified on the form, but thought it could be due to not sleeping and trazodone (antidepressant) was started on 5/9/17. DON stated after looking in risk management, a fall investigation was not completed following the fall on 5/11/17. DON further stated by reading the progress note dated 5/11/17, it was not clear if the fall mat was on the floor at the time of the fall on 5/11/17. DON stated she expected all fall interventions to be followed. DON stated following the fall on 5/11/17, she added an intervention for R24 to be toileted on the first night shift rounds, but did not complete a bladder assessment to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 70	F 323		

identify if toileting times was a potential cause of the fall. DON stated R24's shoes had never been evaluated for safety and stated the shoes had been removed on 6/1/17, and family was contacted. DON further stated when reviewing falls at the IDT meetings, the fall investigation was not always looked at to try and determine the cause of the fall to put effective interventions into place. DON further stated falls can not be effectively evaluated without looking at a complete investigation. DON further stated she was aware of incomplete documentation and lack of interventions following a fall for resident's at the facility and she developed a plan in quality assurance to fix the situation, however; had not had the opportunity to train the nurses on the complete documentation and lack of interventions immediately following a fall.

A facility policy Falls-Clinical Protocol dated 5/13, directed staff to, "For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall ... If underlying causes cannot be readily identified, or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try and get up and walk without waiting for assistance)."

WANDERGUARD MONITORING:

R75's admission MDS dated 2/21/17, identified R75 had moderate cognitive impairment and wandering behavior that placed R75 at risk of getting to a potentially dangerous place.

R75's care plan dated 2/15/17, indicated R75 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 71	F 323		

at risk for elopement related to attempts of leaving the facility and wandering. R75's goals were to have no incidence of elopement and remain safe during placement at the facility. Further, the care plan indicated an intervention of, "Wanderguard placed." Review of the medical record revealed no elopement attempts since 2/17.

R75's Treatment Administration Records (TAR's) were reviewed from 2/1/17,-5/31/17. The TAR's lacked any order or documentation to check R75's Wanderguard for placement or function until 5/31/17, when the nursing order was written to, "Check function of wanderguard daily," and "Check wanderguard every shift for placement and skin concerns."

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.

When observed on 5/31/17, at 7:17 p.m. R75 was lying in his bed on top of the blankets, fully clothed. He was watching television. R75 did not have a Wanderguard on. The Wanderguard was located on his bedside table, however; the band on the Wanderguard was broken.

During interview on 5/31/17, at 7:18 p.m. R75 stated he used to wear a Wanderguard on his wrist, but the band on the Wanderguard broke about three weeks ago. R75 stated he told the staff the band was broken on the Wanderguard, but no one had fixed it or given him a new Wanderguard. R75 stated sometimes he kept the Wanderguard in his pants pocket and sometimes in his coat pocket, but not always.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 72	F 323		

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.

When interviewed on 6/1/17, at 7:54 a.m. NA-K stated R75 was an elopement risk and wore a Wanderguard located on his wheelchair. She stated she was not aware if any staff checked the placement or checked to see if R75's Wanderguard was working. NA-K stated she did not know how to check if a Wanderguard was working, adding, "That is a good question."

During interview on 6/1/17, at 8:04 a.m. NA-J stated R75 did not wear a Wanderguard. NA-J stated staff do not check to see if a resident wears a Wanderguard, adding staff was just aware of which residents wandered.

When interviewed on 6/1/17, at 8:35 a.m. LPN-A stated R75 wore a Wanderguard on his left ankle and it was checked every shift to make sure it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 73	F 323		

was on and the nurses documented in the resident's medication administration record. LPN-A stated the night shift staff checked the function of the Wanderguard. LPN-A stated the order for checking R75's Wanderguard had just got entered on 5/31/17, and prior to 5/31/17, no one was checking the placement or function of R75's Wanderguard. When informed the Wanderguard was on his right wrist, LPN-A stated she was not aware of that and thought it was located on his ankle.

A facility Code Alert Wandering Monitor System policy dated 8/2013, indicated on a weekly basis each transmitter in use would be tested by the nurse of each resident who wore the transmitter unit. The alarm and transmitter would be tested by taking the resident through the alarmed doors and document appropriately in the resident's medical record. The policy also indicated the wrist or ankle band would be checked on a weekly basis for wear and tear, and replaced as necessary. This would be documented in the resident's medical record.

SMOKING:

R75's admission 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 74	F 323		

interventions which included, "Independent with smoking per evaluation" and "Smoking apron per evaluation."

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 identified R75 required adaptive equipment which included a "Smoking apron." The smoking evaluation summary and interventions indicated R75 was able to safely get himself outside, light his own cigarette, and properly dispose of his cigarette. R75 was accepting of wearing a smoking apron and accepting of facility smoking times. The smoking policy and times were also reviewed with R75 and his significant other and they agreed to them.

During interview on 5/30/17, at 1:32 p.m. R75 stated he went outside four times a day to smoke and there were specific times of the day posted by the nurse's station of when he could go out to smoke. He also stated the staff gave him his cigarettes when it was time to go out to smoke.

During observation on 5/30/17, at 1:32 p.m. R75 went outside to the smoking patio in his wheelchair. He had a smoking apron on his lap, but the smoking apron was not opened. The apron remained folded on his lap the entire time he was outside smoking. R75 was able to light his cigarette by himself, ash safely, and extinguish his cigarette without difficulty. However, the entire time R75 was smoking, the safety apron remained folded on his lap. There was 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 75	F 323		

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. 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.

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.

On 5/31/17, at 7:23 p.m. NA-H stated R75 was a smoker and he went outside to smoke. She further stated R75 had to wear a smoking apron when he was smoking and she did not believe R75 needed a staff member to be outside with R75 when he smoked.

During interview on 5/31/17, at 7:26 p.m. TMA-A stated R75 was a smoker. She further stated residents that smoke were evaluated to be safe smoking and if the resident was able to light, ash, and extinguish safely, the resident was allowed to smoke. TMA-A also stated for extra safety, residents had to wear a smoking apron.

When interviewed on 5/31/17, at 7:44 p.m. the DON stated R75 was a smoker and R75 was asked to wear a smoking apron when he went outside to smoke. The DON further stated R75 usually just set the smoking apron on his lap when he smoked. DON added, if R75's smoking assessment indicated R75 was supposed to be wearing a smoking apron, then he "should have been wearing it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 76	F 323		

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 smoked per his smoking evaluation. 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. LPN-A also added R75 often just placed it on his lap. "This could potentially be a problem."

R27's admission MDS dated 4/3/17, identified R27 had moderate cognitive impairment and currently used tobacco products.

R27's most recent Smoking Evaluation Form dated 5/25/17, identified R27 had no cognitive loss and was alert and orientated. The evaluation identified R27 had no visual deficits which could interfere with his ability to smoke safely, however, listed a question, "Can the resident safely utilize lighter/matches?" This was answered as, "No," by the evaluator. Further, the evaluation identified R27 was determined to be able to smoke independently and listed, "Facility specific interventions including need for adaptive equipment," with a written, "X" placed next to, "Smoking apron [device covering skin and clothes to prevent burns from dropped ashes]."

R27's care plan dated 4/20/17, identified R27 to be currently smoking while at the nursing home with a goal listed of, "Resident will smoke safely." Further, the care plan listed interventions including, "Use walker while going outside to smoke," and, "Smoking apron per evaluation."

During observation on 5/30/17, at 1:34 p.m. R27 came to the nursing station and was provided a folded up gray colored smoking apron, lighter and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 77 three single cigarettes from licensed practical nurse (LPN)-E. R27 ambulated outside using his walker and sat in a chair on the patio. R27 placed the folded up smoking apron on the table outside and proceeded to light his cigarette(s) and smoke them. R27 did not drop any ashes and had no burn holes visible in his clothing. R27 stated the staff was aware he was not wearing the provided smoking apron but had, "never questioned it." During interview on 6/1/17, at 8:52 a.m. NA-D stated R27 went outside to smoke several times during her shift at the designated, "smoke times." NA-D stated R27 took the smoking apron outside with him and staff only assisted him with it if he wanted it as, "That's up to him." NA-D stated use of the smoking apron was, "Highly recommended," though to reduce the risk of burns. NA-D stated she had never been directed to monitor R27 when he is outside smoking. When interviewed on 6/1/17, at 12:16 p.m. the assistant director of nursing (ADON) stated R27 should be using the smoking apron as directed by his most recent evaluation. A facility Resident Smoking Policy dated 6/14, indicated residents that required supervision and/or assistance with smoking would be evaluated for need of adaptive equipment (i.e., flame retardant apron, cigarette extension holder). Any resident who did not comply with this policy would lose independent smoking privileges, until re-evaluated and determined to be safe to smoke independently.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 78 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and justify the need for a cholesterol-lowering medication for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/14/17, indicated R21 had severe cognitive impairment, and had diagnoses including hypercholesterolemia (high cholesterol), hypertension, Parkinson's disease, and arthropathy (disease of a joint). R21's Order Summary Report dated 5/17/17, indicated R21 had current physician orders for, Simvastatin,(cholesterol reducing medication) 20 milligrams (mg) by mouth at bedtime related to other and unspecified hyperlipidemia with an order date of 2/8/14. Further, the Order Summary Report directed staff to draw the following labs, "Cholesterol panel and LFT's (liver function tests) q (every) 9 months" with an order date of 2/8/14. R21's Chemistry report dated 8/21/15, identified R21's cholesterol level was 132 mg/dL (milligrams per deciliter), triglyceride level 73 mg/dL, high density lipoprotein cholesterol 47 mg/dL, low density cholesterol 70 mg/dL, total bilirubin 0.8 mg/dL, direct bilirubin 0.2 mg/dL, all were within the normal range. However, R21's medical record lacked evidence her cholesterol level and liver function tests had been re-checked as ordered since 8/21/15 (a period of 22 months).	F 329	F 329 a. R 21 had cholesterol level checked 6/5/2017. b. All residents will be reviewed at next care conference to ensure proper lab monitoring is reviewed to ensure resident does not receive unnecessary medications. c. Education provided to nursing staff to ensure monitoring of lab orders and completion as ordered by provider. Clinical pharmacist will be educated on monitoring unnecessary labs ordered and or unnecessary medications for residents. d. Director of Nursing will complete a monthly Audit of 3 resident clinical pharmacist reviews to ensure the monitoring unnecessary labs ordered and or unnecessary medications for residents. Audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 80	F 329		

During interview on 6/2/17, at 2:20 p.m. the director of nursing (DON) stated R21 had a physician's order written on 2/10/14, to have a lipid and liver function test drawn every nine months. The DON stated she was unable to determine if these labs had been drawn as ordered. The DON further stated she was unable to find any documentation in R21's medical record to show these labs had been drawn as ordered.

When interviewed on 6/2/17, at 2:39 p.m., consulting pharmacist (CP) stated he was, "probably going to ask" to have R21's cholesterol and liver function tests discontinued. CP stated the reason R21's cholesterol and liver function tests were drawn was because R21 was on Risperdal (an anti-psychotic medication), but that medication was discontinued on 12/16. CP also stated since the discontinuance of R21's Risperdal, he saw no reason to keep such a close eye on R21's cholesterol level. CP stated because of R21's age, he was a lot less aggressive with treating R21's cholesterol levels. CP stated the plan was to continue to address R21's cholesterol level with Simvastatin, and, added "It doesn't really matter" if the Simvastatin if effective or not, because there was no plan to change R21's therapy. CP added potential side effects of Simvastatin included muscle pain and muscle weakness, but stated he would not even begin to suspect R21's use of Simvastatin was a cause of R21's muscle weakness.

During a subsequent interview on 6/2/17, at 3:23 p.m. the DON stated R21's cholesterol and liver function tests should have been drawn as ordered, and the facility should have identified the labs were not being completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 81 When interviewed on 6/5/17, at 1:38 p.m. the medical director (MD) stated it was, "not at all important" to check cholesterol and liver function tests because it really does not make a difference. The MD also stated physician orders, "should be followed." The MD stated she really questioned residents' need to be on statins (class of drugs used to lower cholesterol levels) while in the nursing home. A facility Medication Management policy dated 6/15, indicated to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. Further, the policy indicated the medication regimen was evaluated periodically to determine whether prolonged or indefinite use of a medication was indicated.	F 329		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced	F 425		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 82 by: Based on observation, interview and document review, the facility failed to ensure medication orders were reconciled accurately to prevent administration errors for 1 of 7 residents (R26) observed to receive medications during the survey. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/28/17, identified R26 had moderate cognitive impairment. Further, the MDS identified R26 had alcoholic cirrhosis of the liver and consumed a diuretic medication (used to reduce fluid in the body) daily. R26's physician fax signed 4/27/17, identified R26 had complaints of, "Water retention," and requested her Lasix (a diuretic) be increased to 40 mg being given twice a day (a total of 80 mg administered). The physician responded with, "Yes," adding, "But only if she consents to daily weights and plans to see me within 2 weeks." During observation of medication administration on 5/31/17, at 6:18 p.m. licensed practical nurse (LPN)-B prepared R26's medications at a mobile cart in the hallway. LPN-B provided a package to the surveyor of the medications to be administered which included a single Lasix 40 mg tablet. The package was dispensed from an automated machine and did not include administration instructions. LPN-B reviewed R26's Medication Administration Record (MAR) which directed, "Furosemide Tablet 20 mg Give 2 tablet [40 mg] by mouth two times a day [for a total of 80 mg daily as directed by the fax dated 4/27/17] ...". LPN-B administered the single 40	F 425	F 425 a. R 26 orders were reviewed for accuracy and to ensure all orders were processed to prevent medication errors b. All resident orders will be reviewed to ensure all orders are processed to prevent medication errors. c. Education provided to all licensed nurses on medication reconciliation and timely processing of orders. Nursing staff will review all orders daily for proper processing. d. Director of Nursing or designee will complete an audit of 3 residents with new orders to ensure proper medication reconciliation and timely processing to prevent medication errors. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 83	F 425		

mg tablet of Lasix to R26.

R26's medical record was reviewed for current medication orders. R26's physician visit note dated 5/9/17, identified R26 had been seen by her physician and included a section labeled, "Your Updated Medication List," which listed several orders including, "Furosemide [Lasix] 20 mg tablet," with directions, "Take 3 tablets [60 mg] by mouth once daily." This document was signed on the front by nursing home staff and dated 5/11/17.

An additional subsequent physician visit note dated 5/17/17, identified R26 had been seen in the emergency room for a, "Fall, Initial Encounter," and, "Soft tissue complaint." The note listed a section labeled, "Your Medications," with directions to, "Take these medicines as prescribed by your regular doctor. These medicines were not reviewed at the hospital." The section provided several medication orders including, "Furosemide 20 mg tablet," and directed, "Take 3 tablets [60 mg] by mouth every morning," for alcoholic cirrhosis of the liver with ascites (fluid build up in the abdomen).

R26's nursing progress note dated 5/18/17, identified R26 returned from the emergency department with, "no new orders." The note did not identify if the difference in Lasix dosing had been clarified.

When interviewed on 6/1/17, at 11:55 a.m. the assistant director of nursing (ADON) stated she reviewed R26's hard chart and MAR. R26 had been getting Lasix 40 mg twice a day (a total of 80 mg a day) since the faxed order was signed on 4/27/17, however, had been seen several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 84 times, both in the clinic and emergency department since then. The order listed at each visit was Lasix 20 mg three times a day (a total of 60 mg a day). ADON stated she called the clinic and spoke with R26's physician who stated the 80 mg a day being administered was correct, not the 60 mg a day being identified on the visit note(s). The ADON stated nursing home staff, "should of looked," at the paper work and clarified the orders to ensure R26 was receiving the correct dose of Lasix. The ADON added the discrepancy had been missed by, "several" different staff members who should have reviewed the paperwork. Further, ADON stated the discrepancy not being clarified could cause a medication error for R26. A facility medication reconciliation policy was requested, but none was provided.	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities	F 428		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 85 to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that monthly pharmacy reviews had recommendations for necessary lab work for monitoring of medications for 1 of 5 residents (R21) reviewed for unnecessary medications, who was prescribed a	F 428	F 428 a. R 21 had cholesterol level checked 6/5/2017. b. All residents will be reviewed to ensure proper lab monitoring is completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 86 cholesterol-lowering medication. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/14/17, indicated R21 had severe cognitive impairment, and had diagnoses including hypercholesterolemia (high cholesterol), hypertension, Parkinson's disease, and arthropathy (disease of a joint). R21's Order Summary Report dated 5/17/17, indicated R21 had current physician orders for, Simvastatin,(cholesterol reducing medication) 20 milligrams (mg) by mouth at bedtime related to other and unspecified hyperlipidemia with an order date of 2/8/14. Further, the Order Summary Report directed staff to draw the following labs, "Cholesterol panel and LFT's (liver function tests) q (every) 9 months" with an order date of 2/8/14. R21's Chemistry report dated 8/21/15, identified R21's cholesterol level was 132 mg/dL (milligrams per deciliter), triglyceride level 73 mg/dL, high density lipoprotein cholesterol 47 mg/dL, low density cholesterol 70 mg/dL, total bilirubin 0.8 mg/dL, direct bilirubin 0.2 mg/dL, all were within the normal range. However, R21's medical record lacked evidence her cholesterol level and liver function tests had been re-checked as ordered since 8/21/15 (a period of 22 months). R21's monthly Pharmacy Review notes dated 8/1/16 to 5/23/17, lacked identified concerns with R21's lack of laboratory monitoring with her ongoing use of simvastatin. During interview on 6/2/17, at 2:20 p.m. the	F 428	per orders c. Education provided to nursing staff to ensure monitoring of lab orders and completion as ordered. d. Director of Nursing or designee to complete an audit of 3 residents to ensure completion of lab monitoring as ordered. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 87	F 428		

director of nursing (DON) stated R21 had a physician's order written on 2/10/14, to have a lipid and liver function test drawn every nine months. The DON stated she was unable to determine if these labs had been drawn as ordered. The DON further stated she was unable to find any documentation in R21's medical record to show these labs had been drawn as ordered.

When interviewed on 6/2/17, at 2:39 p.m., consulting pharmacist (CP) stated he was, "probably going to ask" to have R21's cholesterol and liver function tests discontinued. CP stated the reason R21's cholesterol and liver function tests were drawn was because R21 was on Risperdal (an anti-psychotic medication), but that medication was discontinued on 12/16. CP also stated since the discontinuance of R21's Risperdal, he saw no reason to keep such a close eye on R21's cholesterol level. CP stated because of R21's age, he was a lot less aggressive with treating R21's cholesterol levels. CP stated the plan was to continue to address R21's cholesterol level with Simvastatin, and, added "It doesn't really matter" if the Simvastatin if effective or not, because there was no plan to change R21's therapy. CP added potential side effects of Simvastatin included muscle pain and muscle weakness, but stated he would not even begin to suspect R21's use of Simvastatin was a cause of R21's muscle weakness.

During a subsequent interview on 6/2/17, at 3:23 p.m. the DON stated R21's cholesterol and liver function tests should have been drawn as ordered, and the facility should have identified the labs were not being completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 88 When interviewed on 6/5/17, at 1:38 p.m. the medical director (MD) stated it was, "not at all important" to check cholesterol and liver function tests because it really does not make a difference. The MD also stated physician orders, "should be followed." The MD stated she really questioned residents' need to be on statins (class of drugs used to lower cholesterol levels) while in the nursing home. A facility Consultant Pharmacist Services Provider Requirements policy dated 6/15, indicated the consultant pharmacist was responsible for reviewing the medication regimen of each resident at least monthly and document the review and findings in the resident's medical record or in a readily retrievable format. The policy also identified the consultant pharmacist was responsible for communication to the responsible prescriber and the facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues at least monthly.	F 428		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide	F 431		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 89	F 431		

pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 90 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure safe storage of controlled substances to reduce the risk of potential diversion for 2 of 2 residents (R39, R5) observed to have refrigerated medications. Further, the facility failed to implement practices to ensure rapid detection of potential narcotic diversion for 2 of 2 medication carts reviewed during the survey. This had potential to affect 13 of 13 residents identified with current orders for narcotic medications in the facility. Findings include: UNSECURED MEDICATIONS: A facility Controlled Substance Storage policy dated 6/15, identified medications classified as controlled substances were, "subject to special handling, storage, disposal and record-keeping in the facility in accordance with federal, state and other applicable laws and regulations." The policy directed, "Schedule II - V [two through five] medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications or per state regulation." On 5/30/17, at 9:40 a.m. the medication room was reviewed with licensed practical nurse (LPN)-A. The room was locked by physical key and a small Danby Designer refrigerator was on	F 431	F 431 a. Medication room will remain locked at all times except when in the presence of a licensed nurse. Shift to shift narcotic counts will be completed at shift change. b. Medication room will remain locked at all times except when in the presence of a licensed nurse. Shift to shift narcotic counts will be completed at shift change. c. Policy and procedure for the facility Controlled Substance policy was reviewed and remains current. Education provided to licensed nursing staff that handle narcotic medications on the facility Controlled Substance Storage policy, ensuring medication room remaining locked at all times except in the presence of a licensed nurse, and signing of the Shift to shift narcotic counts to be completed at the end of one shift and prior to the start of the next shift to prevent diversion. d. Director of Nursing or designee to complete an audit of medication room to ensure it remains locked except in the presence of a licensed nurse and to complete an audit of each shift to shift narcotic count sheets to ensure they are completed at the change of each shift. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 91	F 431		

the floor underneath the counter. On the side of the refrigerator was a hinge device and a unlocked gold colored pad lock inserted through the hinge. The padlock was removed from the refrigerator without having to use a key and the refrigerator contents reviewed. Contents included two opened bottles of lorazepam (an anti-anxiety medication and class IV controlled substance) inside - one each for R39 and R5. The amount of remaining medication inside the bottles was reviewed with the bound register count and found to be correct.

When interviewed immediately following the observation, LPN-A stated the refrigerator should have been kept locked, "because there's Ativan [lorazepam] in there." LPN-A stated lorazepam was considered to be a narcotic medication and should be double locked at all times.

During interview on 6/2/17, at 11:41 a.m. the director of nursing (DON) stated lorazepam stored in the refrigerator, "should be double locked," at all times to prevent potential diversion.

When interviewed on 6/2/17, at 2:29 p.m. the consulting pharmacist (CP) stated the lorazepam should have been double locked according to the facility policy, "It should of been locked."

LACK OF DOCUMENTED RECONCILIATION:

On 5/30/17, at 9:20 a.m. the South medication cart was reviewed with licensed practical nurse (LPN)-A. A separate locked metallic cabinet was affixed to the cart and when opened contained several various narcotic medications. LPN-A stated narcotics were counted, "between each shift," and the count was signed as being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 92	F 431		

completed on a flowsheet in the binder housed on the medication carts. LPN-A provided the binder to the surveyor which contained a Change Of Shift Controlled Substance Count Sheet dated 5/17. The flowsheet contained several columns for nurses to record narcotic count information including the date, shift with additional spacing for each shift nurse to sign as they count with arrival and departure. A total of six signatures were required to satisfy the counting requirements as laid out on the flowsheet. However, several fields were left blank and unsigned as follows:

May 1 - One of six spaces was left blank;
May 4 - One of six spaces was left blank;
May 5 - Three of six spaces, being the AM to PM shift and PM to NOC [night] count, was left blank;
May 9 - One of six spaces was left blank;
May 12 - One of six spaces was left blank;
May 17 - One of six spaces was left blank;
May 18 - One of six spaces was left blank;
May 24 - One of six spaces was left blank;
May 27 - One of six spaces was left blank;

When interviewed during the medication cart review on 5/30/17, LPN-A stated the sheets should be signed by each oncoming and departing nurse. LPN-A stated she had never witnessed the carts not being counted by two nurses at change of shift but added, "I'm sure it happens" when counts are sometimes missed and not completed. Further, LPN-A stated the sheets should be completed with double signatures for each count, "To make sure it was completed," and so staff are aware, "Who counted last and when it was done last."

The North medication carts Change Of Shift Controlled Substance Count sheets dated 5/17,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 93	F 431		

were reviewed and identified the same flowsheet used, however, again, several fields were left blank and unsigned as follows:

May 1 - one of six spaces was left blank;
May 5 - two of six spaces, being the entire AM shift, was left blank;
May 12 - two of six spaces was left blank;
May 15 - one of six spaces was left blank;
May 26 - two of six spaces, again being the entire AM shift, was left blank and;
May 27 - one of six spaces was left blank.

A random narcotic count was completed and all medications were found to be correct with LPN-A.

Subsequent past months of controlled substance tracking sheets were requested and reviewed which again identified several unsigned spaces for each medication cart in which the shift to shift narcotic count was undocumented.

When interviewed on 6/2/17, at 11:41 a.m. the director of nursing (DON) stated narcotic medications should be counted, "at every shift change," and documented on the controlled substance count sheets. The DON stated she felt the carts were being counted, "[I] just think they are not signing." The DON stated the nurses should be signing the sheets as, "part of the policy," in order to ensure the count is correct and, "decrease the chance of diversion."

During interview on 6/2/17, at 2:29 p.m. the consulting pharmacist (CP) stated he had completed some medication cart audits within the past six months or so and identified the shift to shift narcotic count was not being correctly documented adding, "I picked up on that as well."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 94 CP stated he notified the DON of these concerns who, "corrected the staff." Further, CP stated the count should be documented according to the facility policy to ensure, "rapid detection," was possible if diversion occurred to, "find out who took what." During subsequent interview on 6/2/17, at 2:38 p.m. the DON stated she was never made aware of any concerns with medication cart narcotic counts not being documented in the past several months by the CP. A signed listing provided by the DON on 6/2/17, identified 13 residents in the facility had current orders for narcotic medications. A facility Controlled Substance Storage policy dated 6/2015, identified medications classified as controlled substances were, "...subject to special handling, storage, disposal and record-keeping in the facility in accordance with federal, state and other applicable laws and regulations." The policy directed, "At each shift change, or when keys are transferred, a physical inventory of all controlled substances ... is conducted by two licensed nurses and is documented."	F 431		
F 490 SS=F	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 95 Based on interview and document review, the facility administration failed to ensure allegations of abuse and mistreatment were identified timely, taken appropriate actions to protect residents and thoroughly investigate allegations for 1 of 1 residents (R15) reviewed who alleged staff abuse. The failure of administration to implement their abuse prevention plan and ensure potential abuse was not occurring in the facility had potential to affect all 35 current residents in the facility. Findings include: See F225; as the facility failed to immediately identify potential abuse, take action to protect residents from potential abuse or thoroughly investigate incidents to determine corrective action to be taken. 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	F 490	F 490 a. R 15 allegations were thoroughly investigated per policy. b. Residents educated during Resident Council on 6/27/2017 on their rights and responsibilities of being in a safe environment and their rights regarding the Abuse Prevention/Vulnerable Adult Plan. All residents were interviewed to ensure that they felt safe in the environment and all abuse allegations were investigated thoroughly. c. Policy and procedure for Abuse Prevention/Vulnerable Adult Plan policy reviewed and remains current. All staff were educated to the Abuse Prevention/Vulnerable Adult Plan. Education on completing a thorough investigation completed administrator, director of nursing, social services, and assistant director of nursing. d. Administrator or Designee will complete an audit with 3 random residents, via interview, to ensure they feel safe in the facility and abuse allegations are investigated timely and thoroughly. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 96	F 490		

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 on vacation, she was the nurse on duty to field calls were there any allegations of abuse. When asked why she did not take more timely action in regarding to R15 when she learned of the incident between staff and R15, the DON stated she did not get a "100% clear" picture of the situation, and that "it did not register." The DON stated she had not interviewed R15 about this incident. The DON stated the survey team found "something alarming" and were were now trying to keep the residents safe.

During interview on 6/2/17 at 4:32 p.m., the administrator talked about how the facility's abuse prohibition policy worked and of his ultimate responsibility for the residents in the facility. The administrator described pre-employment finger printing, background screening, job shadowing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 97 and training required of all staff. The administrator stated, as mandated reporters, staff was able to identify what abuse was and take action, and added, since today's training, that "they [staff] do now" know what and when to report. The administrator also talked about R15's alleged abuse incident in early May and stated he did not see a system breakdown. The Administrator acknowledged that the nursing assistants, who were involved in R15's incident, did not make a report or allege abuse took place, nor did the facility take action to follow up with R15. Further, the facility did not thoroughly investigate R15's incident, nor think to take steps to protect R15 and other residents from potential harm as a result of this incident. After reading the progress note about incident from 5/2/17, between R15 and the staff, the administrator stated "nothing glaring popped out" and stated he would have responded as the DON had, without taking further action. The administrator stated stated prior to survey team's findings staff, including himself, did not perceive a concern of potential abuse with R15, nor the need of protecting R15 or other residents. The administrator stated that when he learned of the incident on 6/1/17, as a result of the survey team's findings, he took immediate action, and that having gone through the immediate jeopardy process, stated "I will act differently now." The Administrator stated, moving forward, we learned "to be more thorough."	F 490		
F 495 SS=F	483.35(d)(3) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY (d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that	F 495		7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 495	Continued From page 98 facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure nursing assistants were provided at least 16 hours of training before direct resident contact for 2 of 5 nursing assistants (NA-G, NA-H) whose training files were reviewed. This had the potential to affect all 35 residents who resided at the facility. Findings include: Nursing assistant personnel training files were reviewed and indicated: NA-G was hired on 3/17/17, and began direct resident care 4/11/17. The file contained no evidence NA-G had at least 16 hours of training prior to providing direct resident care. NA-H was hired on 1/9/17, and began direct resident care on 1/11/17. The file contained no evidence NA-H had at least 16 hours of training prior to providing direct resident care. During an interview with human resources (HR)-A and HR-B on 6/2/17, at 12:35 p.m. HR-A stated	F 495	F 495 a. NA-G and NA-H completed necessary training. 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 new hires have the required training prior to providing direct care to residents within the facility. d. Administrator or Designee will complete an audit of a random selection of new hires to ensure proper training has occurred prior to providing direct care to residents within the facility. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 495	Continued From page 99	F 495		

nursing assistant (NA)-G was hired on 3/17/17, and started working the floor and having direct contact with the residents on 4/11/17. HR-A stated the personnel record for NA-G did not contain certification from the nursing assistant registry before starting direct contact residents. HR-A also indicated NA-G's personnel file did not contain evidence of the required 16 hour training, before resident contact.

HR-A stated NA-F, hired on 1/9/17, started to work on the floor and had direct contact with residents beginning on 1/11/17. HR-A also stated the personnel record for NA-F did not contain certification from the nursing assistant registry before starting direct contact with the residents. HR-A also indicated NA-F's personnel file did not contain evidence of the required 16 hours of training, before resident contact.

On 6/2/17, at 2:00 p.m., NA-F stated that she was assigned to a mentor during her orientation, and that she started having direct patient contact "a few days" after being hired. NA-F stated she was enrolled in a nursing assistant class for certification, but did not have 16 hours of training before beginning to work on the floor with resident contact.

A audit tool titled: Facility Compliance Delano was from Healthcare Academy. (A web based training company for inservice education) The tool included records for courses assigned out and completed by student between 3/1/17, and 5/31/17, confirmed that NA-F did not complete and courses for inservice training.

During an interview on 6/1/17 at 10:44 a.m., the DON stated employee records may be with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 495	Continued From page 100 previous owner. Copies of the employee records were requested, but were not provided.	F 495		
F 498 SS=F	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide inservice training to ensure the continuing competence of 3 of 5 nursing assistants (NA-C, NA-N, and NA-O) reviewed who are currently employed. This had the potential for affect all 35 residents who reside at the facility.	F 498	F 498 a. NA-C, NA-N, and NA-O were provided training (12 hours) to ensure their continued competence. b. All nursing assistants will have required training (12 hours) to ensure their continued competence.	7/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 498	Continued From page 101 Findings include: Nursing assistant (NA) personnel training files were reviewed and indicated: NA-C was hired on 12/2/15 The personnel file contained no evidence of successful completion of 12 hours of inservice education per year, and there was no evidence of a yearly performance evaluation. NA- N was hired on 4/17/94, the personnel file contained no evidence of successful completion of 12 hours of inservice education per year. NA-O was hired on 7/12/08, the personnel file contained no evidence of successful completion of 12 hours of education per year. On 6/2/17, at approximately 3:30 p.m. human resource assistant (HR)-A and HR-B, reviewed the files for NA-C, NA-N, and NA-O. HR-A, and HR-B were unable to present the necessary documentation to confirm 12 hours of education yearly. Additionally, the personnel file for NA-C did not have a performance evaluation completed since 2015. HR-A stated that the director of nursing (DON) may have the records. An audit tool titled: Facility Compliance Delano was from Healthcare Academy. (A web based training company for inservice education) The tool included records for courses assigned out and completed by student between 3/1/17, and 5/31/17, which confirmed NA-C, NA-N, and NA-O did not complete any hours of inservice education. When interviewed on 6/2/17, at 3:45 p.m., the	F 498	c. Education has been provided to staffing coordinator to ensure all current nursing assistants need to be provided training (12 hours) to ensure their continued competence, or they need to be removed from the schedule. d. Administrator or Designee will complete an audit of a random selection of current employees to ensure required training hours are completed. Audits will occur weekly times 4, monthly times 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 498	Continued From page 102 director of nursing (DON) stated the nursing assistants' records were requested from the previous owner, and were not available. The performance evaluation for NA-C was requested and not available. A policy was requested for nursing assistant training requirements, none was provided.	F 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	K 000	EPOC	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as one building. The Estates at Delano is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II (000) construction. In 1988 a single story addition was constructed to the South Wing and determined to be of Type II (000) construction. An addition was constructed in 2008 and was determined to be Type II (000) to the East Wing. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 35 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=C	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. The deficient practice could affect 35 out of 35 residents. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/31/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System was unavailable during the survey. This deficient practice was verified by the	K 346	K 346 a. Fire Alarm System Out-of-Service Policy and Procedure was updated in the Maintenance Director binder to include all of the required steps in the event that the fire alarm system needs to be taken off-line for more than 4 hours in a 24 hour period. The policy and procedure now includes the required notification of the authorities that have jurisdictional authority over The Estates at Delano Skilled Nursing Facility which includes the Deputy State Fire Marshall Inspector and the Delano Fire Department. In the event the system needs to be taken off-line all parties will either be evacuated from the facility that are left unprotected by the shutdown until the fire alarm system is returned to service. Or an approved fire watch will be conducted to protect all parties checking all areas of the building a minimum of every 30 minutes until the fire alarm system is back on-line and fully	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 346	Continued From page 3 Housekeeping Supervisor and Administrator.	K 346	functioning as required by NFPA 101. b. Maintenance Director or designee will ensure that when all future maintenance to the fire alarm system is conducted by Summit Companies, or another approved vendor, on the fire alarm and sprinkler system that the Fire Alarm System Out-of-Service policy and procedure is followed as required by NFPA 101. c. Education will be provided to Environmental Services, Maintenance, and Administration to ensure compliance of the Fire Alarm System Out-of-Service policy consistent with the requirements outlined by NFPA 101. d. Administrator or designee will require the request the Maintenance Director to receive prior approval by the Administrator or designee before conducting any updates, repairs, or preventative maintenance on either the Fire Alarm System or the Fire Sprinkler System to ensure compliance with the Out-of-Service Policy and Procedure for the Fire Alarm System Out-of-Service policy and procedure requirements outlined by NFPA 101.	
K 354 SS=C	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management	K 354		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 354	Continued From page 4 or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. The deficient practice could affect 35 out of 35 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/31/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System Policy was not available during the survey.	K 354	K 354 a. Sprinkler System Out-of-Service Policy and Procedure was updated in the Maintenance Director binder to include all of the required steps in the event that the sprinkler system needs to be taken off-line or if it is impaired in any way for more than 10 hours in a 24 hour period. If the sprinkler system is impaired or off-line, the extent and duration of the impairment or off-line status will be determined, the areas of the building involved will be inspected and risks will be determined. Recommendations will be submitted to management or designated representative, and the Delano Fire Department and the Deputy State Fire Marshall Inspector and any other jurisdiction entity over The Estates at Delano Skilled Nursing Facility will be notified as required by NFPA 101. In the event the sprinkler system needs to be taken off-line all parties will either be evacuated from the facility that are left unprotected by the shutdown until the building fire sprinkler system is returned to service. Or an approved fire watch will be conducted to protect all parties checking	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 354	Continued From page 5 This deficient practice was verified by the Housekeeping Supervisor and Administrator.	K 354	all areas of the building a minimum of every 30 minutes until the sprinkler system is back on-line and fully functioning. b. Maintenance Director or designee will ensure that when all future maintenance to the building fire sprinkler system is conducted by Summit Companies, or another approved vendor, on the fire alarm and sprinkler system that the Sprinkler System Out-of-Service policy and procedure is followed as required by NFPA 101. c. Education will be provided to Environmental Services, Maintenance, and Administration to ensure compliance of the Sprinkler Alarm System Out-of-Service policy consistent with the requirements outlined by NFPA 101. d. Administrator or designee will require the request the Maintenance Director to receive prior approval by the Administrator or designee before conducting any updates, repairs, or preventative maintenance on either the Fire Alarm System or the Fire Sprinkler System to ensure compliance with the Out-of-Service Policy and Procedure for the Building Fire Sprinkler System Out-of-Service Policy and Procedure requirements outlined by NFPA 101.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall	K 521		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 6 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it is revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation. Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/31/2017, observations revealed that the heating, ventilation, and air conditioning systems for the building is using the corridor system as part of the air distribution system for make-up air for the bathrooms exhaust. This deficient practice was verified by the Housekeeping Supervisor and Administrator. An annual waiver was previously granted.	K 521	K 521 a. 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, previously known as Golden Living Center Delano #00874, had an approved waiver the year prior for both North and South corridors using the corridors as part of the heating ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. Compliance with this provisions as identified in K521 would impose an unreasonable hardship on the facility due to the disruption during the 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. And the structural integrity of the building would potentially be compromised by the installation of the required equipment. (See Attached Update Waiver Request for NFPA 101 HVAC)	
K 712 SS=C	NFPA 101 Fire Drills	K 712		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 7 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: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 35 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/31/2017 record review and staff interview revealed one fire drill was done on the wrong shift in the third quarter of 2016. This deficient practice was verified by the Housekeeping Supervisor and Administrator.	K 712	K 712 a. Fire drills that 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 an audible alarm. b. An audit system has been established to ensure that the required fire drills will be conducted at unexpected times, under varying conditions, and on each shift a minimum of quarterly in compliance with the requirements of NFPA 101 Fire Drills.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 8	K 712	c. The Administrator or designee will audit the Maintenance Director to ensure compliance with the requirement for fire drills conducted at unexpected times, under varying conditions, and on each shift a minimum of quarterly in compliance with the requirements of NFPA 101 Fire Drills. d. The Maintenance Director and Administrator or designee will present the required quarterly fire drills alternating each shift to the monthly QAPI meeting to ensure compliance with the required guidelines for Fire Drills as outlined by NFPA 101 for Fire Drills.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 9 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 facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect 15 of the 35 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/31/2017 observations and staff interview revealed in resident room 3B a refrigerator plugged into a power strip and into another power strip and not directly into a wall outlet. Medical equipment was also plugged into the power strips. This deficient practice was verified by the Housekeeping Supervisor and Administrator.	K 920	K 920 a. The power strip plugged into a refrigerator in room 3B that was plugged into another power strip before reaching the wall outlet was removed. Also, the medical equipment in room 3B that was plugged into a power strip was plugged directly into the wall outlet as required by NFPA 101 for Electrical Equipment – Power Cords and Extension Cords. Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE, except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245336	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/31/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 10	K 920	requirements as outlined by NFPA 101 for Electrical Equipment – Power Cords and Extension Cords. Any identified violations of the Electrical Equipment – Power Cord and Extension Cord requirements will be immediately resolved for all residents. c. Education will be provided to all staff relating to the requirements outlined by NFPA 101 for Electrical Equipment – Power Cords and Extension Cords to monitor future compliance. d. The Maintenance Director or designee will conduct a NFPA 101 for Electrical Equipment – Power Cords and Extension Cords audit of 5 resident rooms weekly and presented to the QAPI meeting monthly. The frequency of audits will be adjusted depending on the results of the audit.	

Name of Facility: The Estates at Delano (previously Golden Living Center Delano #00874)
Waiver for K521 Survey Date: May 31, 2017

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K521	Waiver Request for 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, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is being requested for the following reasons: 1. There will be no adverse effect on the health and safety of the facility's residents, family members, and staff because the building is equipped with an approved full smoke detector system, along with an automated full shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or sprinkler system. 2. The facility is protected by a 24 hour supervised automatic sprinkler system. 3. The internal facility is smoke-free and signs are prominently posted at all major entrances/exits. There is a designated exterior smoking area on the far end of the patio in the back of the building, used only by a few residents. The area is equipped with approved metal self-closing containers for used cigarettes. 4. Annual service and maintenance contracts exist to service all the facility's fire protection system including fire alarm, sprinkler system, and portable extinguishers. 5. The building fire alarm system is monitored to provide automatic fire department notification. 6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 7. Fire drills are conducted quarterly on each shift. 8. Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. The initial bid also proposed the installation of duct work that would negatively affect the structural integrity of the building. The Estates at Delano was not able to find a more cost effective solution for making the ventilation system upgrades to meet the current codes NFPA 90A. Submitted by: Don Flack, Administrator - June 27,2017

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
[signature]	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	07-24-17

K 521

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

MDH
Minnesota
Department
of Health

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 only a suggestion 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On May 30. 2017 through June 2, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 185	MN Rule 4658.0060. A. Responsibilities of Administrator; reports The administrator is responsible for the: A. maintenance, completion, and submission of reports and records as required by the department; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility administration failed to ensure allegations of abuse and mistreatment were identified timely, taken appropriate actions to protect residents and thoroughly investigate allegations for 1 of 1 residents (R15) reviewed who alleged staff abuse. The failure of administration to implement their abuse prevention plan and ensure potential abuse was not occurring in the facility had potential to affect all 35 current residents in the facility. Findings include: See F225; as the facility failed to immediately identify potential abuse, take action to protect residents from potential abuse or thoroughly investigate incidents to determine corrective action to be taken.	2 185	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 185	Continued From page 3 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	2 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 185	Continued From page 4 on vacation, she was the nurse on duty to field calls were there any allegations of abuse. When asked why she did not take more timely action in regarding to R15 when she learned of the incident between staff and R15, the DON stated she did not get a "100% clear" picture of the situation, and that "it did not register." The DON stated she had not interviewed R15 about this incident. The DON stated the survey team found "something alarming" and were were now trying to keep the residents safe. During interview on 6/2/17 at 4:32 p.m., the administrator talked about how the facility's abuse prohibition policy worked and of his ultimate responsibility for the residents in the facility. The administrator described pre-employment finger printing, background screening, job shadowing, and training required of all staff. The administrator stated, as mandated reporters, staff was able to identify what abuse was and take action, and added, since today's training, that "they [staff] do now" know what and when to report. The administrator also talked about R15's alleged abuse incident in early May and stated he did not see a system breakdown. The Administrator acknowledged that the nursing assistants, who were involved in R15's incident, did not make a report or allege abuse took place, nor did the facility take action to follow up with R15. Further, the facility did not thoroughly investigate R15's incident, nor think to take steps to protect R15 and other residents from potential harm as a result of this incident. After reading the progress note about incident from 5/2/17, between R15 and the staff, the administrator stated "nothing glaring popped out" and stated he would have responded as the DON had, without taking further action. The administrator stated stated prior to survey team's findings staff,	2 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 185	Continued From page 5 including himself, did not perceive a concern of potential abuse with R15, nor the need of protecting R15 or other residents. The administrator stated that when he learned of the incident on 6/1/17, as a result of the survey team's findings, he took immediate action, and that having gone through the immediate jeopardy process, stated "I will act differently now." The Administrator stated, moving forward, we learned "to be more thorough." SUGGESTED METHOD OF CORRECTION: The facility board of directors (BOD) could review its policies and procedures regarding the administrator's role in abuse/neglect/VA reporting. The BOD could educate the administrator on his/her role and responsibility. The BOD could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 185		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:	2 265		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 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	2 265	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7 ulcers and did not currently have pressure ulcers. R18's Skin Evaluation dated 3/29/17, indicated a Stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on the right heel measuring 2 centimeters (cm) x 2 cm. The note indicated it was a blister. The assessment also identified a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) to the left heel measuring 2 cm x 1 cm x 0.3 cm. The assessment did not include any further description of the pressure ulcers, interventions, physician notification or treatment initiated. R18's medical record lacked evidence the physician was notified of the change in condition of R18's skin. On 6/2/17, at 11:31 a.m. a telephone message was left for R18's physician. On 6/5/17, at 1:38 p.m., via telephone, R18's physician stated she was not aware R18 developed two Stage 2 pressure ulcers. The physician further stated she would expect to be notified when a resident developed pressure ulcers for appropriate treatment. LACK OF NOTICE WITH ROOM CHANGE: R12's significant change Minimum Data Set (MDS) dated 5/2/17, identified R12 had severe cognitive impairment and was totally dependent on staff for transfers and off-unit locomotion. During interview on 5/30/17, at 2:01 p.m. R12's responsible party, family member (FM)-A stated	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 8	2 265		

R12 had changed rooms within the past nine months and she was not notified of this change prior to it happening. FM-A stated she would have liked to had been told of it prior, instead of showing up to the nursing home to visit and finding R12 not in the same room adding, "It would be helpful to improve communication from here [nursing home] to home."

R12's undated electronic medical record (EMR) census information identified R12 changed rooms in 1/17. R12's medical record was reviewed and lacked any evidence FM-A was told of the room change prior to it occurring.

When interviewed on 6/2/17, at 8:54 a.m. licensed social worker (LSW)-A stated she reviewed R12's medical record and was unable to locate any documentation demonstrating R12's responsible party had been notified of the room change, "I didn't find any." Further, LSW-A stated FM-A should have been notified so, "The family knows where to find them," and are not placed in a situation to wonder, "Where did my loved one go," when they next come visit as happened to FM-A.

A GL Resident Room Relocation policy (in effect at the time of room change for R12) dated 12/1/16, identified a resident, "has the right to receive written notice ... before the resident's room or room mate in the Living Center is changed." The policy directed social services staff to provide notice to the resident, "and his or her legal representative or interested family member with a written notice and documenting in the medical record."

A policy on notification of change was requested and not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems for notification of change. The DON or designee could inservice staff regarding facility practices, policy and procedures for notifications of change. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide inservice training to ensure the continuing competence of 3 of 5 nursing assistants (NA-C, NA-N, and NA-O) reviewed who are currently employed. This had the potential for affect all 35 residents who reside at the facility. Findings include: Nursing assistant (NA) personnel training files were reviewed and indicated:	2 300	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 10 NA-C was hired on 12/2/15 The personnel file contained no evidence of successful completion of 12 hours of inservice education per year, and there was no evidence of a yearly performance evaluation. NA- N was hired on 4/17/94, the personnel file contained no evidence of successful completion of 12 hours of inservice education per year. NA-O was hired on 7/12/08, the personnel file contained no evidence of successful completion of 12 hours of education per year. On 6/2/17, at approximately 3:30 p.m. human resource assistant (HR)-A and HR-B, reviewed the files for NA-C, NA-N, and NA-O. HR-A, and HR-B were unable to present the necessary documentation to confirm 12 hours of education yearly. Additionally, the personnel file for NA-C did not have a performance evaluation completed since 2015. HR-A stated that the director of nursing (DON) may have the records. An audit tool titled: Facility Compliance Delano was from Healthcare Academy. (A web based training company for inservice education) The tool included records for courses assigned out and completed by student between 3/1/17, and 5/31/17, which confirmed NA-C, NA-N, and NA-O did not complete any hours of inservice education. When interviewed on 6/2/17, at 3:45 p.m., the director of nursing (DON) stated the nursing assistants' records were requested from the previous owner, and were not available. The performance evaluation for NA-C was requested and not available.	2 300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 300	Continued From page 11 A policy was requested for nursing assistant training requirements, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure appropriate training is in place for staff holding certifications/licensure. The DON or designee could educate all appropriate staff on those systems,. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R22) reviewed for admission, transfer and discharge practices was notified timely prior to a change in	2 435	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 435	Continued From page 12 roommate. Findings include: R22's annual Minimum Data Set (MDS) dated 4/12/17, identified R22 had intact cognition. During interview on 5/30/17, at 11:33 a.m. R22 stated he had a roommate change within the past several months and was not notified prior, "[Staff] just bring them in." R22 stated he would have liked to have some notice of a new roommate coming before they 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. R22's medical record was reviewed and lacked any documentation to demonstrate R22 had been informed of the new roommate prior to their arrival in the facility. When interviewed on 6/1/17, at 8:54 a.m. licensed social worker (LSW)-A stated the facility used, "Room change forms" to alert residents when they are getting a roommate; however, LSW-A stated she was unable to locate this for R22's recent roommate change in 3/17. LSW-A stated she spoke with the corporate consultant staff and the documented note of him being upset, "shows he was informed he was getting one." Further, LSW-A stated the facility had no way to demonstrate R22 was told prior to the new	2 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 435	Continued From page 13 roommate arriving, but he should have been given as much warning as possible to, "make sure he had time to calm down and adjust to it." An undated facility policy, Room or Roommate Change, identified a, "Room or roommate 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. SUGGESTED METHOD OF CORRECTION: The social service director (SSD) or designee could develop systems to ensure residents are aware of changes in rooms/room mates as timely as possible. The SSD or designee could educate all appropriate staff on those systems. The SSD 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 CORRECTION: Twenty-one (21) days.	2 435		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care planned interventions to prevent injury for 1 of 2 residents (R24) reviewed for falls, and 2 of 2 residents (R75, R27) reviewed for safety with smoking and/or wandering. Further, the facility failed to follow the plan of care for wound monitoring for 1 of 3 residents (R44) reviewed for pressure ulcers. Findings include: R24's annual Minimum Data Set (MDS) dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified diagnoses of hypertension, arthritis, dementia and anxiety. The MDS identified R24 needed extensive assistance for bed mobility, transfers, and ambulation and indicated R24 had two or more falls without injury since the last assessment dated 1/25/17. R24's care plan revised on 3/8/17, indicated a potential for falls/ accidents. Risk factors included use of medications, pain, a fall in 6/14, which resulted in intracranial hemorrhage with impaired mobility, impulsivity and cognition which placed him at higher risk for falls. The care plan indicated R24 had fallen several more times since the initial fall. A fall matt at the bedside was listed as a fall intervention. R24's undated Group D nursing assistant sheet included a fall mat. A progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off at 1:20 a.m. and staff found him lying on his stomach "on the floor" in a pool of blood. The blood was coming	2 565	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 15 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. During interview on 5/31/17, at 7:56 p.m. nursing assistant NA-H stated the fall matt was not on the floor as directed. NA-H looked for the fall matt and could not find it. NA-H left the room and went to help another resident. 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. During interview on 6/2/17, at 10:33 a.m. the director of nursing (DON) stated, based on the information charted on the fall dated 5/11/17, it didn't sound as if the fall matt was on the floor. The DON further stated assessed fall interventions were expected to be followed. WANDERGUARD: R75's admission MDS dated 2/21/17, identified moderate cognitive impairment and wandering behavior which placed him at risk for getting to a potentially dangerous place. R75's care plan dated 2/15/17, indicated R75 was at risk for elopement related to attempts of leaving the facility and wandering. R75's goals were to have no incidence of elopement and to remain safe during placement at the facility. The care plan identified an intervention of, "Wanderguard placed."	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 16 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. When observed on 5/31/17, at 7:17 p.m. R75 was lying in his bed on top of the blankets, fully clothed. He was watching television. R75 did not have a Wanderguard on. The Wanderguard was located on his bedside table, however, the band on the Wanderguard was broken. During interview on 5/31/17, at 7:18 p.m. R75 stated he used to wear a Wanderguard on his wrist, but the band on the Wanderguard broke several weeks ago. R75 stated he told the staff the band had broken on the Wanderguard, but no one had fixed it or given him a new one. R75 stated sometimes he kept the Wanderguard in his pants pocket or his coat pocket, but not always. When interviewed on 5/31/17, at 7:26 p.m. TMA-A stated R75 wore a Wanderguard. At 7:30 p.m. TMA-A went to R75's room and found the Wanderguard sitting on his bedside table. TMA-A stated R75 should have it attached to his body and not sitting on the bedside table. When interviewed on 6/1/17, at 7:54 a.m. NA-K stated R75 was an elopement risk and wore a Wanderguard located on his wheelchair. During interview on 6/1/17, at 8:04 a.m. NA-J stated R75 did not wear a Wanderguard. When interviewed on 6/1/17, at 12:18 p.m. the director of nursing (DON) stated she expected staff to follow a resident's care plan. The DON further stated, not having the Wanderguard attached to R75 was considered not following the care plan.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 17 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 an admitting diagnosis of, "Tobacco Use." R75's care plan dated 3/22/17, indicated "Resident currently smokes at this facility," and included a goal for R75 of, "Resident will smoke safely." The care plan listed interventions which included, "Independent with smoking per evaluation," and, "Smoking apron per evaluation." 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	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 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 smoked per his 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 considered not following the care plan. R27's admission Minimum Data Set (MDS) dated 4/3/17, identified moderate cognitive impairment	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 19 and indicated R27 currently used tobacco products. R27's care plan dated 4/20/17, identified R27 was currently smoking while at the nursing home. R27's care planned goal was, "Resident will smoke safely." Further, the care plan listed interventions including, "Use walker while going outside to smoke," and, "Smoking apron per evaluation." R27's Smoking Evaluation Form dated 5/25/17, indicated R27 was able to smoke independently and listed, "Facility specific interventions including need for adaptive equipment," with a written, "X" placed next to, "Smoking apron [device covering skin and clothes to prevent burns from dropped ashes]." During observation on 5/30/17, at 1:34 p.m. R27 came to the nursing station and was provided a folded up gray colored smoking apron, lighter and three single cigarettes from licensed practical nurse (LPN)-E. R27 then ambulated outside using his walker. R27 placed the folded up smoking apron on the table outside and proceeded to light his cigarette(s) and smoke them. R27 stated the staff was aware he was not wearing the provided smoking apron but had, "never questioned it." During interview on 6/1/17, at 8:52 a.m. nursing assistant (NA)-D stated R27 took the smoking apron outside with him and staff only assisted him with using it if he wanted it as, "That's up to him." NA-D stated use of the smoking apron was, "highly recommended" though, to reduce the risk of burns. When interviewed on 6/1/17, at 12:16 p.m. the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 20	2 565		

assistant director of nursing (ADON) stated care plans were used to, "make sure every resident is getting their independent needs met," and staff were expected to follow it. The ADON further stated R27 should be using the smoking apron as directed by his evaluation and care plan.

LACK OF ADEQUATE WOUND MONITORING:

R44's annual Minimum Data Set (MDS) dated 4/26/17, identified R44 had moderate cognitive impairment, required extensive assistance with activities of daily living (ADLs), had a current stage III (described as full thickness tissue loss) pressure ulcer and remained at risk for pressure ulcer development.

R44's care plan dated 5/8/17, identified R44 had a pressure ulcer due to bowel and bladder incontinence and limited mobility. The care plan identified R44 had a current stage III pressure ulcer on his buttock and directed staff to complete, "Weekly wound assessment," and, "Conduct weekly skin inspection."

During observation on 6/2/17, at 9:57 a.m. licensed practical nurse (LPN)-C completed R44's dressing change. LPN-C stated she did not routinely measure the ulcer with dressing changes as, "that's only scheduled or whatever." LPN-C completed no measurements/data collection of R44's pressure ulcer.

When interviewed on 6/2/17, at 10:26 a.m. LPN-C stated she was unaware who was assigned or responsible to measure and document characteristics of pressure ulcers. LPN-C stated floor staff only measure the pressure ulcer if directed to do so by the treatment administration record (TAR).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 21 R44's TAR dated 4/25/17, to 5/30/17, directed staff, "Complete Weekly wound evaluation [Monarch Health Management (MHM) Weekly Wound Evaluation] under forms tab for coccyx wound." This was scheduled to be completed on a weekly basis on 4/26/17, 5/3/17, 5/10/17, 5/17/17, 5/24/17 and 5/31/17. However, on 5/3/17, the entry was recorded as, "Absent from home," and on 5/10/17, the entry was recorded as, "Drug refused." Further, on 5/17/17, the entry was recorded as, "Other / See Nurses Notes." R44's MHM Weekly Wound Evaluation dated 4/30/17, 5/1/17, 5/19/17, and 5/30/17 identified R44 had a stage III pressure ulcer on his coccyx. Additionally, the evaluations contained measurements of the stage III pressure ulcer. The evaluations further identified R44 visited a wound clinic. Although evaluations contained data, there was no comprehensive weekly wound assessment as directed by the plan of care. R44's medical record was reviewed. There was no additional documentation identified to demonstrate R44's pressure ulcer and associated characteristics had been monitored/assessed on a weekly basis as directed by the care plan and to ensure healing. When interviewed on 6/2/17, at 11:35 a.m. the director of nursing (DON) stated the floor nurses were responsible to measure and document R44's pressure ulcer on a weekly basis using the MHM Weekly Wound Evaluation form(s) in the electronic medical record. The DON reviewed R44's medical record and stated his pressure ulcer had not been tracked weekly, but should have been, "for continued monitoring to ensure the wound is healing," and R44's, "treatment	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 22 [was] still effective." A facility policy on implementation of the care plan was requested, but 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 CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 830	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23	2 830		

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 being unsteady and not able to stabilize himself 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 24 months and indicated R24 was a moderate risk for falls. R24's care plan revised on 3/8/17, identified R24 had a potential for falls/ accidents. Risk factors included the use of medications, pain, a fall in 6/14, which resulted in an intracranial hemorrhage, resulting in impaired mobility/cognition, impulsivity, and placing him at higher risk for falls. The care plan identified R24 had fallen several more times since the initial fall. Interventions included: bed in low position, fall mat on floor bedside, mobility monitors on R24's bed and chair; ensure they are on and working, anticipate needs, provide rest periods, keep call light within reach when in room, keep environment free of clutter, monitor vital signs weekly, and monitor for medication side effects. R24's undated Group D nursing assistant sheet indicated safety interventions for R24 were low bed, floor mat and sensor alarm. R24's progress note dated 3/3/17, at 3:00 a.m. indicated R24's alarm was going off down the South Hall by the scale. R24 was found on his left side with a skin tear to the top of the left hand and a pink area to the left forehead. The Minnesota Incident Report dated 3/3/17, at 3:00 a.m. identified a possible cause of the fall was anxiety as the resident was propelling himself constantly. No interventions for R24 were listed on the form. The Fall Scene Investigation dated 3/3/17, at 3:20 a.m. identified R24 was last seen at 2:45 a.m., however; the areas for last time toileted, positioned, and offered fluids was blank on the form. The Post Fall Investigation/ Plan signed 3/6/17, indicated R24 was last toileted at 12:45 a.m. and an intervention added for staff to fold the scale when not in use. The rest of the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 25	2 830		

form was blank. Although an intervention of folding the scale was implemented, it did not address R24's anxiety or initiate an intervention related to R24's anxiety.

R24's progress note dated 5/4/17, at 2:00 a.m. indicated R24 had a fall from from his bed and was found lying on his right side on his "floor mat" between his night stand and his bed. R24 received an injury of two skin tears. The right elbow skin tear measured 2 centimeters (cm) x 0.5 cm. The right shoulder skin tear measured 3 cm x 0.5 cm. The fall investigation dated 5/3/17, indicated R24 had no environmental factors, no predisposing physiological factors, had dementia, and ambulating/transferring without assist with improper/no footwear. No predisposing factors were identified. Immediate action taken was first aid to the skin tears and due to the resident's continued restlessness, staff assisted him to his wheelchair. The Incident Review and Analysis dated 5/5/17, identified potential causative factors as "unknown." Interventions added were to remove the over the bed table, and move the night stand away from the bed. Although interventions were added to reduce the chance of injury, it did not address a potential cause or an intervention to minimize the risk of a subsequent fall.

R24's progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off in R24's room at 1:20 a.m. Staff found R24 lying on his stomach "on the floor" in a pool of blood, coming from a head laceration. R24 left with the paramedics at 1:55 a.m. There was no fall investigation. The Incident Review and Analysis dated 5/15/17, identified potential causative factors as resident attempting to get out of bed, unable to state why, but suspect toileting needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 26 Intervention added was to toilet on first night rounds. R24's 5/11/17, emergency room discharge report indicated he received seven sutures to a head laceration from his fall. This fall was similar to the fall on 5/3/17, however; the progress note did not indicate R24 was found on his fall mat or if the fall mat was in place at the time of the fall. There was no investigation completed to determine the details of the fall and minimize potential risk of further falls. During observation on 5/30/17, at 2:34 p.m. R24 was seated in his wheelchair wearing yellow Crocs sandals that did not have a strap behind the ankle. During observation on 5/31/17, at 7:37 p.m. R24 was lying in bed without a fall mat on the floor by the bedside. A pair of faded yellow Crocs sandals were on the floor. The bottom of the sandals were worn, as there was little tread remaining on the bottom of either sandal. During interview on 5/31/17, at 7:56 p.m. nursing assistant 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 stated the only shoes R24 wore were the yellow Crocs sandals. NA-H also stated that when R24 was propelling his wheelchair with his feet his Crocs sandals often fell off. NA-H then left the room and went to help another resident. No floor mat was put by R24's bedside. During interview on 5/31/17, at 8:06 p.m. trained medication aid (TMA)-A stated a fall mat was to be on the floor next to R24's bed. TMA-A stated the fall mat was not at the bedside on the floor. TMA-A found the fall mat behind R24's door and placed it on the floor near R24's bed. TMA-A	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 27 observed R24's sandals and stated they were worn. TMA-A further stated, "I don't like them [Crocs sandals], dumbest thing for an elderly man to wear." During interview on 6/1/17, at 1:12 p.m. licensed practical nurse (LPN)-A stated an intervention is initiated right away following a fall "if we know the source" of the fall. LPN-A stated there was not a falls committee to her knowledge, but falls were reviewed at stand up meetings Monday through Friday. LPN-A stated R24 usually had gripper socks on or the yellow Crocs sandals. LPN-A observed the Crocs sandals and stated there was no tread on the bottom of the sandals, "I think we need to take those away, I'm going to take those out." LPN-A then removed the sandals from R24's room. 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. 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 there 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."	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 28 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 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 up meeting on business days, but stated the IDT is struggling with consistency of meetings at this time. During interview on 6/2/17, at 9:37 a.m. NA-D stated the scale at the end of the South Hall was supposed to be folded up when not in use. NA-D also stated it was left in the down position most of the time. During interview on 6/2/17, at 10:33 a.m. the director of nursing (DON) stated the fall process had changed since switching management companies a few months ago. When a resident falls the nurse is supposed to document the fall in the progress notes and fill out an investigation form in risk management. The DON stated the nurses should be putting an immediate intervention into place to try and prevent further falls and not just assessing and treating the immediate injuries. DON stated the IDT review had been "bumpy" and had not consistently been	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29	2 830		

reviewing falls the following business day. DON stated she completed the Incident Review and Analysis following the IDT review of the fall. DON stated R24's fall on 5/3/17, happened on a Wednesday and the IDT did not review the incident until 5/5/17, on a Friday and stated a potential cause was not identified on the form, but thought it could be due to not sleeping and trazodone (antidepressant) was started on 5/9/17. DON stated after looking in risk management, a fall investigation was not completed following the fall on 5/11/17. DON further stated by reading the progress note it was not clear if the fall mat was on the floor at the time of the fall on 5/11/17. DON stated she expected all fall interventions to be followed. DON stated following the fall on 5/11/17, she added an intervention for R24 to be toileted on the first night shift rounds, but did not complete a bladder assessment to identify if toileting times was a potential cause of the fall. DON stated R24's shoes had never been evaluated for safety and stated the shoes had been removed on 6/1/17, and family was contacted. DON further stated when reviewing falls at the IDT meetings, the fall investigation was not always looked at to try and determine the cause of the fall to put effective interventions into place. DON further stated falls can not be effectively evaluated without looking at a complete investigation. DON further stated she was aware of incomplete documentation and lack of interventions following a fall for resident's at the facility and she developed a plan in quality assurance to fix the situation, however; had not had the opportunity to train the nurses on the complete documentation and lack of interventions immediately following a fall.

A facility policy Falls-Clinical Protocol dated 5/13, directed staff to, "For an individual who has fallen,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 30 staff will attempt to define possible causes within 24 hours of the fall ... If underlying causes cannot be readily identified, or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try and get up and walk without waiting for assistance)." LACK OF WANDERGUARD MONITORING: R75's admission Minimum Data Set (MDS) dated 2/21/17, identified R75 had moderate cognitive impairment and wandering behavior that placed R75 at risk of getting to a potentially dangerous place. R75's care plan dated 2/15/17, indicated R75 was at risk for elopement related to attempts of leaving the facility and wandering. R75's goals were to have no incidence of elopement and remain safe during placement at the facility. Further, the care plan indicated an intervention of, "Wanderguard placed." Review of the medical record revealed no elopement attempts since 2/17. R75's Treatment Administration Records (TAR's) were reviewed from 2/1/17,-5/31/17. The TAR's lacked any order or documentation to check R75's Wanderguard for placement or function until 5/31/17, when the nursing order was written to, "Check function of wanderguard daily," and "Check wanderguard every shift for placement and skin concerns." 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.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 31 When observed on 5/31/17, at 7:17 p.m. R75 was lying in his bed on top of the blankets, fully clothed. He was watching television. R75 did not have a Wanderguard on. The Wanderguard was located on his bedside table, however; the band on the Wanderguard was broken. During interview on 5/31/17, at 7:18 p.m. R75 stated he used to wear a Wanderguard on his wrist, but the band on the Wanderguard broke about three weeks ago. R75 stated he told the staff the band was broken on the Wanderguard, but no one had fixed it or given him a new Wanderguard. R75 stated sometimes he kept the Wanderguard in his pants pocket and sometimes in his coat pocket, but not always. 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. When interviewed on 6/1/17, at 7:54 a.m. NA-K	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 32 stated R75 was an elopement risk and wore a Wanderguard located on his wheelchair. She stated she was not aware if any staff checked the placement or checked to see if R75's Wanderguard was working. NA-K stated she did not know how to check if a Wanderguard was working, adding; "That is a good question." During interview on 6/1/17, at 8:04 a.m. NA-J stated R75 did not wear a Wanderguard. NA-J stated staff do not check to see if a resident wears a Wanderguard, adding staff was just aware of which residents wandered. When interviewed on 6/1/17, at 8:35 a.m. LPN-A stated R75 wore a Wanderguard on his left ankle and it was checked every shift to make sure it was on and the nurses documented in the resident's medication administration record. LPN-A stated the night shift staff checked the function of the Wanderguard. LPN-A stated the order for checking R75's Wanderguard had just got entered on 5/31/17, and prior to 5/31/17, no one was checking the placement or function of R75's Wanderguard. When informed the Wanderguard was on his right wrist, LPN-A stated she was not aware of that and thought it was located on his ankle. A facility Code Alert Wandering Monitor System policy dated 8/2013, indicated on a weekly basis each transmitter in use would be tested by the nurse of each resident who wore the transmitter unit. The alarm and transmitter would be tested by taking the resident through the alarmed doors and document appropriately in the resident's medical record. The policy also indicated the wrist or ankle band would be checked on a weekly basis for wear and tear, and replaced as necessary. This would be documented in the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 33 resident's medical record. 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 interventions which included, "Independent with smoking per evaluation" and "Smoking apron per evaluation." 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 identified R75 required adaptive equipment which included a "Smoking apron." The smoking evaluation summary and interventions indicated R75 was able to safely get himself outside, light his own cigarette, and properly dispose of his cigarette. R75 was accepting of wearing a smoking apron and accepting of facility smoking times. The smoking policy and times were also reviewed with R75 and his significant other and they agreed to them. During interview on 5/30/17, at 1:32 p.m. R75 stated he went outside four times a day to smoke and there were specific times of the day posted by the nurse's station of when he could go out to smoke. He also stated the staff gave him his	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 34 cigarettes when it was time to go out to smoke. During observation on 5/30/17, at 1:32 p.m. R75 went outside to the smoking patio in his wheelchair. He had a smoking apron on his lap, but the smoking apron was not opened. The apron remained folded on his lap the entire time he was outside smoking. R75 was able to light his cigarette by himself, ash safely, and extinguish his cigarette without difficulty. However, the entire time R75 was smoking, the safety apron remained folded on his lap. There was 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. 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. 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. On 5/31/17, at 7:23 p.m. nursing assistant (NA)-H stated R75 was a smoker and he went outside to smoke. She further stated R75 had to wear a smoking apron when he was smoking and she did not believe R75 needed a staff member to be outside with R75 when he smoked. During interview on 5/31/17, at 7:26 p.m. trained medication aide (TMA)-A stated R75 was a	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 35	2 830		

smoker. She further stated residents that smoke were evaluated to be safe smoking and if the resident was able to light, ash, and extinguish safely, the resident was allowed to smoke. TMA-A also stated for extra safety, residents had to wear a smoking apron.

When interviewed on 5/31/17, at 7:44 p.m. the director of nursing (DON) stated R75 was a smoker and R75 was asked to wear a smoking apron when he went outside to smoke. The DON further stated R75 usually just set the smoking apron on his lap when he smoked. DON added, if R75's smoking assessment indicated R75 was supposed to be wearing a smoking apron, then he "should have been wearing it."

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 smoked per his smoking evaluation. 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. LPN-A also added R75 often just placed it on his lap. "This could potentially be a problem."

R27's admission Minimum Data Set (MDS) dated 4/3/17, identified R27 had moderate cognitive impairment and currently used tobacco products.

R27's most recent Smoking Evaluation Form dated 5/25/17, identified R27 had no cognitive loss and was alert and orientated. The evaluation identified R27 had no visual deficits which could interfere with his ability to smoke safely, however, listed a question, "Can the resident safely utilize lighter/matches?" This was answered as, "No," by the evaluator. Further, the evaluation identified R27 was determined to be able to smoke independently and listed, "Facility specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 36 interventions including need for adaptive equipment," with a written, "X" placed next to, "Smoking apron [device covering skin and clothes to prevent burns from dropped ashes]." R27's care plan dated 4/20/17, identified R27 to be currently smoking while at the nursing home with a goal listed of, "Resident will smoke safely." Further, the care plan listed interventions including, "Use walker while going outside to smoke," and, "Smoking apron per evaluation." During observation on 5/30/17, at 1:34 p.m. R27 came to the nursing station and was provided a folded up gray colored smoking apron, lighter and three single cigarettes from licensed practical nurse (LPN)-E. R27 ambulated outside using his walker and sat in a chair on the patio. R27 placed the folded up smoking apron on the table outside and proceeded to light his cigarette(s) and smoke them. R27 did not drop any ashes and had no burn holes visible in his clothing. R27 stated the staff was aware he was not wearing the provided smoking apron but had, "never questioned it." During interview on 6/1/17, at 8:52 a.m. nursing assistant (NA)-D stated R27 went outside to smoke several times during her shift at the designated, "smoke times." NA-D stated R27 took the smoking apron outside with him and staff only assisted him with it if he wanted it as, "That's up to him." NA-D stated use of the smoking apron was, "Highly recommended," though to reduce the risk of burns. NA-D stated she had never been directed to monitor R27 when he is outside smoking. When interviewed on 6/1/17, at 12:16 p.m. the assistant director of nursing (ADON) stated R27	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 37 should be using the smoking apron as directed by his most recent evaluation. A facility Resident Smoking Policy dated 6/14, indicated residents that required supervision and/or assistance with smoking would be evaluated for need of adaptive equipment (i.e., flame retardant apron, cigarette extension holder). Any resident who did not comply with this policy would lose independent smoking privileges, until re-evaluated and determined to be safe to smoke independently. SUGGESTED METHOD OF CORRECTION: The interdisciplinary team (IDT) could develop safety systems to minimize the risk for resident incidents/injuries as individually assessed to be appropriate for the reisdent. The IDT could educate all staff. The IDT could develop monitoring 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.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical	2 900		7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 38 condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pressure ulcer risk, implement interventions and conduct weekly skin monitoring for 1 of 3 residents (R18), who developed multiple pressure ulcers after admission, resulting in actual harm. In addition, the facility failed to consistently monitor pressure ulcer characteristics for 1 of 3 residents (R44) reviewed who had a current pressure ulcer. Findings include: R18's Admission Record indicated R18 admitted to the facility on 3/15/17. R18's diagnoses included fracture to neck of right femur, idiopathic peripheral autonomic neuropathy and reduced mobility. R18 was discharged from the facility with home care on 3/31/17. R18's hospital discharge summary dated 3/15/17, indicated R18's skin was intact other than surgical wounds covered with dressings R18's Admit/Initial Data Collection dated 3/15/17, indicated 18 separate skin impairment sites as follows: right antecubital, left antecubital, right elbow, left elbow, right thigh front, left thigh front, left knee front, right knee rear, right lower leg	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 39 front, left lower leg front, right lower leg rear, left lower leg rear, right ankle inner, left ankle inner listed twice, right ankle outer listed twice, and left ankle outer. The assessment did not identify the type of skin impairment and lacked any measurements. The assessment did not address any area of concern to either of R18's heels. R18's Tissue Tolerance Observation dated 3/16/17, indicated a lying repositioning schedule of every two hours. The observation did not include a sitting recommendation for repositioning. R18's Braden Scale (assessment to identify pressure ulcer risk) dated 3/20/17, was not completed, the assessment was blank. R18's undated Initial Care Plan (temporary care plan) for skin integrity did not include interventions to minimize pressure ulcer risk. The care plan for mobility/safety directed staff to assist with transfers, assist with bed mobility, and turn and reposition or reminders to offload every two hours and as needed. R18's admission Minimum Data Set (MDS) dated 3/22/17, did not identify R18's cognitive status. The MDS indicated R18 needed extensive assistance with bed mobility and transfers. The MDS identified R18 was at risk to develop pressure ulcers and currently did not have pressure ulcers. The MDS included pressure relieving interventions of a pressure reducing device in bed and a pressure reducing device in the chair. The MDS did not identify a turn and reposition schedule for R18. The MDS further identified use of a diuretic (medication to control fluid).	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 40 R18's pressure ulcer Care Area Assessment (CAA) dated 3/28/17, indicated R18 was at risk to develop pressure ulcers related to a need for extensive assistance with bed mobility and frequent bladder and bowel incontinence. R18 admitted to the facility with surgical incisions with staples to the right hip. R18 had no history of pressure ulcers and no current pressure ulcers. The CAA directed staff to refer to the admission skin assessment and weekly skin assessment. Interventions in place included a pressure reduction mattress and wheelchair cushion. Staff was to assist with turning and repositioning. R18's Skin Evaluation dated 3/29/17, indicated a Stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) on the right heel measuring 2 centimeters (cm) x 2 cm. Staff identified the area as a blister. The assessment also identified a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) to the left heel measuring 2 cm x 1 cm x 0.3 cm. The assessment did not include any further description of the pressure ulcers, interventions, physician notification or treatment initiated. There was no evidence a Skin Evaluation was completed the previous week on 3/22/17, as the treatment sheet directed, although it was initialed as completed. 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.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 41 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. LPN-C stated a skin assessment form was required weekly and it was not acceptable to just initial off on the treatment sheet. LPN-C stated the treatment sheet was a reminder to complete the assessment. LPN-C further stated the Braden assessments were completed by the registered nurse who did the MDS assessment. LPN-C stated if a new pressure area was identified, a treatment would be initiated, along with notifying the physician, family and director of nursing. LPN-C stated the floor nurse admitting the resident was responsible to fill out all areas of the temporary care plan. On 6/2/17, at 9:20 a.m. registered nurse (RN)-A looked at the initial care plan and stated the skin	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 42	2 900		

risk area did not have any interventions. RN-A then pulled up the 3/20/17, Braden assessment and stated it was blank and had not been completed. RN-A stated the floor nurses were responsible for completing the Braden along with the temporary care plan. RN-A stated when she has time she will assist them with assessments. RN-A further stated the weekly skin assessments were to be documented on the form in the electronic medical record (EMR). RN-A reviewed the 3/29/17, skin assessment and stated it indicated R18 developed two Stage 2 pressure ulcers on her heels. RN-A stated the physician should have been updated along with the managers to ensure treatments were appropriate and the cause of the pressure ulcers could be investigated. RN-A stated she did not visually inspect R18's skin when completing the MDS and relied on nursing documentation in the EMR to do her assessment.

On 6/2/17, at 9:41 a.m. RN-B stated she was not told R18 had developed two Stage 2 pressure ulcers on her heels. RN-B stated the initial care plan needed to be completed within 24 hours of admission and should have included a skin integrity plan with interventions to prevent pressure ulcers. RN-B stated the MDS nurse was responsible for completing the Braden assessment and the floor nurses were required to complete a full skin audit weekly and document the findings on a form. RN-B further stated the MDS nurse should have noticed the assessments were not completed when doing the MDS assessments and should have told a supervisor.

During interview on 6/2/17, at 10:24 a.m. the director of nursing (DON) stated she had identified assessments and care plans for skin were an issue and had started re training staff the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 43	2 900		

previous week. The DON further stated her expectations were timely and complete assessments along with completed temporary care plans. DON stated R18 developing two Stage 2 pressures ulcers after admission was a "concern."

On 6/2/17, at 11:31 a.m. a telephone message was left for R18's physician. On 6/5/17, at 1:38 p.m., via telephone, R18's physician stated she did not have pressure ulcers upon admission to the facility and she was not made aware R18 had developed two Stage 2 pressure ulcers after admission. The physician stated she expected the facility to implement interventions to prevent pressure ulcer and would expect to be notified when a resident developed pressure ulcers in order to provide appropriate treatment.

The undated facility Wound Process Checklist directed staff to "1. Notify MD/Treatment as ordered. 2. Notified family and/or responsible party. 3. Education completed with resident and family/ responsible party including review of risks and benefits. 4. Start weekly wound documentation form. 5. Notify nurse manager/ wound nurse. 6. Complete new tissue tolerance audit. 7. Complete new tissue tolerance evaluation. 8. Refer to dietary. 9. Refer to therapies. 10. Refer to interdisciplinary team members as appropriate. 11. Update care plan 12. Update nursing assignment care list. 13. Communicate in report."

R44's annual Minimum Data Set (MDS) dated 4/26/17, identified R44 had moderate cognitive impairment, required extensive assistance with activities of daily living (ADLs), had a current stage III (described as full thickness tissue loss) pressure ulcer and remained at risk for pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 44 ulcer development. R44's care plan dated 5/8/17, identified R44 had a pressure ulcer due to bowel and bladder incontinence and limited mobility. The care plan identified R44 had a current stage III pressure ulcer on his buttock and directed staff to complete, "Weekly wound assessment," and, "Conduct weekly skin inspection." During observation on 6/2/17, at 9:57 a.m. licensed practical nurse (LPN)-C set up supplies in R44's room to change his pressure ulcer dressing. R44 was in bed on an air mattress, positioned on his left side. LPN-C removed a foam dressing from R44's coccyx exposing a visible pressure ulcer. The removed dressing had no visible drainage present. R44's pressure ulcer appeared to be approximately 2 cm (centimeters) by 1 cm in size. The wound lacked any odor. LPN-C stated she did not routinely measure the ulcer with dressing changes as, "That's only scheduled or whatever." LPN-C sprayed R44's wound using a saline wound cleanser; however, R44 became resistive to the procedure and the dressing change was ceased. LPN-C completed no measurements of R44's pressure ulcer. When interviewed on 6/2/17, at 10:26 a.m. LPN-C stated she was unaware who was assigned or responsible to measure and document characteristics of pressure ulcers. LPN-C stated floor staff only measure the pressure ulcer if directed to by the treatment administration record (TAR). Further, LPN-C stated R44's pressure ulcer, "Looked pretty good," today compared to when she last observed it.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 45	2 900		

R44's Treatment Administration Record (TAR) dated 4/25/17, to 5/30/17, directed staff, "Complete Weekly wound evaluation [Monarch Health Management (MHM) Weekly Wound Evaluation] under forms tab for coccyx wound." This was scheduled to be completed on a weekly basis on 4/26/17, 5/3/17, 5/10/17, 5/17/17, 5/24/17 and 5/31/17. However, on 5/3/17, the entry was recorded as, "Absent from home," and on 5/10/17, the entry was recorded as, "Drug refused." Further, on 5/17/17, the entry was recorded as, "Other / See Nurses Notes."

R44's MHM Weekly Wound Evaluation dated 4/30/17, identified R44 had a stage III pressure ulcer on his coccyx. The ulcer was measured as 2 cm (centimeters; length) X (by) 0.1 cm (width) X 0.3 cm (depth) in size with 100% granulation tissue (red tissue indicative of healing) in the wound bed. The ulcer had no drainage or odor present. Further, the evaluation included a section labeled, "Summary," with, "No new changes. Continues to go to wound clinic every 2 weeks."

R44's MHM Weekly Wound Evaluation dated 5/1/17, (one day after previous evaluation), identified R44 had a stage III pressure ulcer on his coccyx. The ulcer was measured as 2 cm (length) X 0.2 cm (width) X 0.3 cm (depth) in size with 100% granulation tissue (red tissue indicative of healing) in the wound bed. The ulcer was identified to have, "Scant" drainage now present with no odor present. Further, the evaluation again included a section labeled, "Summary," with, "NA [not applicable] - Does go to wound clinic 5/3/17."

R44's subsequent MHM Weekly Wound Evaluation dated 5/19/17, (18 days after last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 46	2 900		

evaluation), identified R44 now had an, "Unstageable [known wound but unable to visualize the wound bed]" ulcer on his coccyx. The ulcer was measured as 2.3 cm (length) X 0.3 cm (width) X 0.4 cm (depth) in size. A, "Further description of the wound," section was left blank with no amount of or type of drainage being selected, along with no dictation of any odor being selected. The only selected option was, "Wound Edges," which were identified as, "Intact." Further, the evaluation again included a section labeled, "Summary," however, this section was left blank.

R44's most recent MHM Weekly Wound Evaluation dated 5/30/17, (10 days after previous evaluation), identified R44 had a stage III pressure ulcer on his coccyx. The ulcer was measured as 1.8 cm (length) X 0.3 cm (width) X 0.4 cm (depth) in size with 50% granulation tissue and 25% slough (dead tissue typically white or yellow in color) in the wound bed. The ulcer was identified to have no drainage or odor present. Further, the section labeled, "Summary," identified, "No changes to care plan at this time. Wound has had some improvement."

R44's medical record was reviewed. There was no additional documentation identified to demonstrate R44's pressure ulcer and associated characteristics had been consistently monitored on a routine basis to ensure appropriate monitoring for healing and need for treatment/intervention changes.

R44's Ridgeview Medical Center Wound & Hyperbaric Healing Center sheets identified he had been seen for treatment and evaluation of his pressure ulcer on 4/19/17, 5/3/17, and 5/17/17. However, none of the provided notes from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 47 center identified any measurements or characteristics of the wound. The most recent visit on 5/17/17, only identified the pressure ulcer to be, "Sl [slightly] less deep," and provided dressing change orders. When interviewed on 6/2/17, at 11:35 a.m. the director of nursing (DON) stated the floor nurses were responsible to measure and document R44's pressure ulcer on a weekly basis using the MHM Weekly Wound Evaluation form(s) in the electronic medical record. The DON reviewed R44's medical record and stated his pressure ulcer had not been tracked weekly, but should have been, "for continued monitoring to ensure the wound is healing," and R44's, "Treatment [was] still effective." A facility Weekly Charting Wound Ulcer Documentation policy dated 9/11, identified a purpose which included, " ...the following components should be a part of your weekly [underlined] charting," and listed several components including the stage of the pressure ulcer, dimensions of the ulcer, and if undermining and/or tunneling is present. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to minimize the risk for pressure ulcer development and rapid healing without infection when pressure ulcers develop. 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 ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication orders were reconciled accurately to prevent potential administration errors for 1 of 7 residents (R26) observed to receive medications during the survey. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/28/17, identified R26 had moderate cognitive impairment. Further, the MDS identified R26 had alcoholic cirrhosis of the liver and consumed a diuretic medication (used to reduce fluid in the body) daily. R26's physician fax signed 4/27/17, identified R26 had complaints of, "Water retention," and requested her Lasix (a diuretic) be increased to 40 mg being given twice a day (a total of 80 mg administered). The physician responded with,	21525	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 49 "Yes," adding, "But only if she consents to daily weights and plans to see me within 2 weeks." During observation of medication administration on 5/31/17, at 6:18 p.m. licensed practical nurse (LPN)-B prepared R26's medications at a mobile cart in the hallway. LPN-B provided a package to the surveyor of the medications to be administered which included a single Lasix 40 mg tablet. The package was dispensed from an automated machine and did not include administration instructions. LPN-B reviewed R26's Medication Administration Record (MAR) which directed, "Furosemide Tablet 20 mg Give 2 tablet [40 mg] by mouth two times a day [for a total of 80 mg daily as directed by the fax dated 4/27/17] ...". LPN-B administered the single 40 mg tablet of Lasix to R26. R26's medical record was reviewed for current medication orders. R26's physician visit note dated 5/9/17, identified R26 had been seen by her physician and included a section labeled, "Your Updated Medication List," which listed several orders including, "Furosemide [Lasix] 20 mg tablet," with directions, "Take 3 tablets [60 mg] by mouth once daily." This document was signed on the front by nursing home staff and dated 5/11/17. An additional subsequent physician visit note dated 5/17/17, identified R26 had been seen in the emergency room for a, "Fall, Initial Encounter," and, "Soft tissue complaint." The note listed a section labeled, "Your Medications," with directions to, "Take these medicines as prescribed by your regular doctor. These medicines were not reviewed at the hospital." The section provided several medication orders including, "Furosemide 20 mg tablet," and	21525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 50	21525		

directed, "Take 3 tablets [60 mg] by mouth every morning," for alcoholic cirrhosis of the liver with ascites (fluid build up in the abdomen).

R26's nursing progress note dated 5/18/17, identified R26 returned from the emergency department with, "no new orders." The note did not identify if the difference in Lasix dosing had been clarified.

When interviewed on 6/1/17, at 11:55 a.m. the assistant director of nursing (ADON) stated she reviewed R26's hard chart and MAR. R26 had been getting Lasix 40 mg twice a day (a total of 80 mg a day) since the faxed order was signed on 4/27/17, however, had been seen several times, both in the clinic and emergency department since then. The order listed at each visit was Lasix 20 mg three times a day (a total of 60 mg a day). ADON stated she called the clinic and spoke with R26's physician who stated the 80 mg a day being administered was correct, not the 60 mg a day being identified on the visit note(s). The ADON stated nursing home staff, "should of looked," at the paper work and clarified the orders to ensure R26 was receiving the correct dose of Lasix. The ADON added the discrepancy had been missed by, "several" different staff members who should have reviewed the paperwork. Further, ADON stated the discrepancy not being clarified could cause a medication error for R26.

A facility medication reconciliation policy was requested, but none was provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure resident medications are appropriately reconciled including but not limited to: MD visits, transfers, hospitalizations,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 51 ER trips, and consults. All appropriate staff could be educated on these systems. 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 CORRECTION: Twenty-one (21) days.	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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure safe storage of controlled substances to reduce the risk of potential diversion for 2 of 2 residents (R39, R5) observed to have refrigerated medications. Further, the facility failed to implement practices to ensure rapid detection of potential narcotic diversion for 2 of 2 medication carts reviewed during the survey. This had potential to affect 13 of 13 residents identified with current orders for narcotic medications in the facility. Findings include: UNSECURED MEDICATIONS: A facility Controlled Substance Storage policy	21610	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 52 dated 6/15, identified medications classified as controlled substances were, "subject to special handling, storage, disposal and record-keeping in the facility in accordance with federal, state and other applicable laws and regulations." The policy directed, "Schedule II - V [two through five] medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications or per state regulation." On 5/30/17, at 9:40 a.m. the medication room was reviewed with licensed practical nurse (LPN)-A. The room was locked by physical key and a small Danby Designer refrigerator was on the floor underneath the counter. On the side of the refrigerator was a hinge device and a unlocked gold colored pad lock inserted through the hinge. The padlock was removed from the refrigerator without having to use a key and the refrigerator contents reviewed. Contents included two opened bottles of lorazepam (an anti-anxiety medication and class IV controlled substance) inside - one each for R39 and R5. The amount of remaining medication inside the bottles was reviewed with the bound register count and found to be correct. When interviewed immediately following the observation, LPN-A stated the refrigerator should have been kept locked, "because there's Ativan [lorazepam] in there." LPN-A stated lorazepam was considered to be a narcotic medication and should be double locked at all times. During interview on 6/2/17, at 11:41 a.m. the director of nursing (DON) stated lorazepam stored in the refrigerator, "should be double locked," at all times to prevent potential diversion.	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 53 When interviewed on 6/2/17, at 2:29 p.m. the consulting pharmacist (CP) stated the lorazepam should have been double locked according to the facility policy, "It should of been locked." LACK OF DOCUMENTED RECONCILIATION: On 5/30/17, at 9:20 a.m. the South medication cart was reviewed with licensed practical nurse (LPN)-A. A separate locked metallic cabinet was affixed to the cart and when opened contained several various narcotic medications. LPN-A stated narcotics were counted, "between each shift," and the count was signed as being completed on a flowsheet in the binder housed on the medication carts. LPN-A provided the binder to the surveyor which contained a Change Of Shift Controlled Substance Count Sheet dated 5/17. The flowsheet contained several columns for nurses to record narcotic count information including the date, shift with additional spacing for each shift nurse to sign as they count with arrival and departure. A total of six signatures were required to satisfy the counting requirements as laid out on the flowsheet. However, several fields were left blank and unsigned as follows: May 1 - One of six spaces was left blank; May 4 - One of six spaces was left blank; May 5 - Three of six spaces, being the AM to PM shift and PM to NOC [night] count, was left blank; May 9 - One of six spaces was left blank; May 12 - One of six spaces was left blank; May 17 - One of six spaces was left blank; May 18 - One of six spaces was left blank; May 24 - One of six spaces was left blank; May 27 - One of six spaces was left blank; When interviewed during the medication cart	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 54	21610		

review on 5/30/17, LPN-A stated the sheets should be signed by each oncoming and departing nurse. LPN-A stated she had never witnessed the carts not being counted by two nurses at change of shift but added, "I'm sure it happens" when counts are sometimes missed and not completed. Further, LPN-A stated the sheets should be completed with double signatures for each count, "To make sure it was completed," and so staff are aware, "Who counted last and when 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 1 - one of six spaces was left blank;
May 5 - two of six spaces, being the entire AM shift, was left blank;
May 12 - two of six spaces was left blank;
May 15 - one of six spaces was left blank;
May 26 - two of six spaces, again being the entire AM shift, was left blank and;
May 27 - one of six spaces was left blank.

A random narcotic count was completed and all medications were found to be correct with LPN-A.

Subsequent past months of controlled substance tracking sheets were requested and reviewed which again identified several unsigned spaces for each medication cart in which the shift to shift narcotic count was undocumented.

When interviewed on 6/2/17, at 11:41 a.m. the director of nursing (DON) stated narcotic medications should be counted, "at every shift change," and documented on the controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 55	21610		

substance count sheets. The DON stated she felt the carts were being counted, "[I] just think they are not signing." The DON stated the nurses should be signing the sheets as, "part of the policy," in order to ensure the count is correct and, "decrease the chance of diversion."

During interview on 6/2/17, at 2:29 p.m. the consulting pharmacist (CP) stated he had completed some medication cart audits within the past six months or so and identified the shift to shift narcotic count was not being correctly documented adding, "I picked up on that as well." CP stated he notified the DON of these concerns who, "corrected the staff." Further, CP stated the count should be documented according to the facility policy to ensure, "rapid detection," was possible if diversion occurred to, "find out who took what."

During subsequent interview on 6/2/17, at 2:38 p.m. the DON stated she was never made aware of any concerns with medication cart narcotic counts not being documented in the past several months by the CP.

A signed listing provided by the DON on 6/2/17, identified 13 residents in the facility had current orders for narcotic medications.

A facility Controlled Substance Storage policy dated 6/2015, identified medications classified as controlled substances were, "...subject to special handling, storage, disposal and record-keeping in the facility in accordance with federal, state and other applicable laws and regulations." The policy directed, "At each shift change, or when keys are transferred, a physical inventory of all controlled substances ... is conducted by two licensed nurses and is documented."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 56 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure medications are appropriately stored and accounted for. 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 CORRECTION: Twenty-one (21) days.	21610		
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 medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hearing devices were consistently offered and audiology was consulted for a change in hearing ability for 1 of 1 residents (R44) who complained about difficulty with hearing. Findings include:	21810	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 57	21810		

R44's annual Minimum Data Set (MDS) dated 4/26/17, identified R44 had moderate cognitive impairment. Further, the MDS identified R44 had, "Minimal difficulty," with hearing and did not use hearing aides.

During interview on 5/30/17, at 11:13 a.m. R44 stated he wanted to, "Find out more about my hearing problems." R44 stated he wanted to get hearing aides but didn't know how. R44 stated his hearing was, "kinda getting bad," and he was having to "strain more," with his hearing. R44 did not have hearing aides in place during the interview.

During subsequent observation on 5/31/17, at 12:52 p.m. R44 was seated in his wheelchair in the hallway. R44 did not have hearing aides in place.

A recent mental health Progress Note dated 3/31/17, identified R44 had been seen for a mood disorder due to a past stroke. The provider visited with R44 and documented, "For most of the questions I asked him, he stated 'I can't hear you.'" The note was unsigned by nursing home staff, and lacked any evidence hearing issue had been reviewed.

When interviewed on 5/31/17, at 7:48 p.m. nursing assistant (NA)-E stated R44 was hard of hearing and, "deaf" in at least one ear. NA-E stated she had never seen R44 wear hearing aides, and did not use them to her knowledge. Further, NA-E stated R44's hearing seemed, "a little worse," in the past months and this had been reported to the nurses, "I believe the nurses are aware of it."

During interview on 6/1/17, at 11:46 a.m. licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 58	21810		

practical nurse (LPN)-A stated R44, "Sometimes," has hearing issues, but did not wear any hearing aides to her knowledge. LPN-A stated she was unaware the NA staff had noticed R44's hearing to be worsening in the past months. LPN-A stated if a resident used hearing aides, they were kept in the medication carts so they are not lost. LPN-A reviewed the medication cart and was unable to locate any hearing aides for R44. Further, LPN-A stated the NA staff should be reporting changes with hearing as, "maybe he needs to see audiology."

R44's Referral/Clinic Form dated 2/19/16, identified R44 had been seen by the physician and identified to have, "asymmetrical hearing loss." The physician provided orders, "May go to audiology for hearing aids [sic]." This was completed on 3/15/16, with no further consults being identified in his medical record.

R44's medical record lacked any evidence R44's worsening hearing had been reported to the physician or referred to audiology for further testing.

When interviewed on 6/1/17, at 12:27 p.m. the assistant director of nursing (ADON) stated R44 had a history of being, "Hard of hearing," with his last hearing appointment being completed, "not that long ago." ADON stated R44 used to have a hearing aide, however, was having behaviors with it. The ADON stated she was unsure where the hearing aide went, but would look for it.

R44's care plan dated 6/18/15, identified R44 was at risk for impaired communication with impaired vision and hearing. The care plan directed staff to, "Ensure placement of hearing aids as needed," and to provide, "Hearing and/or Vision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 59 Consultation as needed." The care plan lacked any identified behaviors regarding his hearing aides. During subsequent interview on 6/1/17, at 1:16 p.m. ADON stated she found R44's hearing aide in the medication room, but was unsure who had removed it from the medication cart and placed it there. ADON stated she had just spoken with R44 who responded to her with, "I can't hear you," but declined to use the hearing aide when offered. ADON stated staff was still expected to attempt to give R44 the hearing aide despite his past behaviors adding, "We need to try." ADON stated the nurses used to have a treatment ordered to ensure this happened, however, it had been accidentally removed when the facility ownership changed and was not carried over. Further, ADON stated if NA staff had noticed worsening hearing, it should have been addressed and a referral made to the audiologist to, "see if there's any changes." A facility policy on coordination of care with audiology services was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure resident hearing needs are met. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance with resident hearing needs and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure allegations of abuse were identified timely, appropriate action taken to immediately provide resident protection and thoroughly investigate the allegations for 1 of 1 residents (R15) resulting in high potential for harm, which resulted in an immediate jeopardy (IJ) situation. Further, the facility failed to report to the State Agency a fall, requiring sutures, when not following the care plan, for 1 of 2 residents (R24) reviewed for accidents. The IJ began on 5/2/17, following interview and during review of a documented altercation between staff and R15, the facility failed to identify potential verbal abuse, take action to immediately protect R15, or thoroughly investigate the circumstances to determine if actual abuse existed. On 5/31/17, at 8:10 p.m., the facility administrator, director of nursing (DON), and facility regional nurse consultant were notified of the IJ for R15. The IJ was removed on 6/2/17, at 3:56 p.m., however, non-compliance	21995	Corrected	7/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 61 remained at the lower scope and severity of D which is isolated with potential for more than minimal harm. Findings include: R15's admission record dated 3/31/17, identified R15 had paraplegia, anxiety disorder, major depressive disorder, borderline personality disorder and sacral region pressure ulcers. R15's quarterly Minimum Data Set (MDS) dated 1/6/17, indicated R15 was cognitively intact, able to express ideas and wants both verbally and non-verbally, make herself understood, and was also able to understand others with clear comprehension. Further, the MDS identified R15 required extensive assistance of two staff for bed 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	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 62	21995		

her question of the repositioning time to NA-C, and NA-C, "got progressively louder." R15 stated it went very quick from being loud to yelling. R15 stated she 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 you don't know how to spell."

R15 continued the interview and verbally identified and confirmed the nursing assistant in this altercation as NA-C, and also stated NA-B was in her room and witnessed the entire incident. R15 stated she had not turned in the grievance form to administration yet, because she was concerned about the sequencing of the events and wanted to ensure it was accurate. R15 stated during the altercation on 5/2/17, after NA-C left the room, NA-B verbally stated to her that, NA-C, "can get a lot worse, be careful." R15 presented the surveyor a form titled, Grievance, that was partially completed. R15 stated she began filling it out on 5/2/17, after the altercation but wanted to make sure it was detailed enough. R15 stated she kept thinking about the altercation in her head and, "I just messed up." R15 then paused and stated, "How can I report if I don't get it exactly right." In additional R15 identified she was afraid of retaliation that she may be given a discharge notice if she complained.

R15 stated since the altercation occurred on 5/2/17, no other staff, including the DON,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 63	21995		

licensed social worker (LSW), or administrator, had come to talk to her about the altercation on 5/2/17, between herself and NA-C. R15 stated the altercation with NA-C "made me feel terrible." R15 stated she had overheard several other staff members talking about the altercation on 5/2/17, which she emphasized this had upset and bothered her as well. Adding, after the altercation LPN-A told her NA-C had a "bad temper." Further, R15 stated she felt, "no one is ever held accountable," at the facility and she questioned if, "anyone would do anything," about her grievance if she completed the form and had turned it in. R15 added the administration had attempted to discharge her from the facility in 2/17, while she was hospitalized. R15 stated she continued to be upset by this, as she had not come to terms with the attempt at discharge. R15 stated she got the Ombudsman involved, who assisted in filing an appeal for the facility's "emergency discharge" action, and the discharge was rescinded.

When interviewed on 5/30/17, at 3:49 p.m. NA-B stated she recalled the altercation between NA-C and R15 which happened on 5/2/17. NA-B stated NA-C and R15 had argued about her turning and repositioning when R15 accused NA-C of "yelling" at her. NA-B stated they were, "stating a fact." NA-B stated NA-C tried repeatedly to verbally make her point, and walked out of the room to regroup. NA-B stated she reported the event to a nurse, but was unable to remember who the nurse was when questioned.

When interviewed on 5/30/17, at 4:03 p.m. NA-C stated she recalled the altercation she had with R15 on 5/2/17, and had reported it to the nurse working on the same night. NA-C stated after the incident she also reported the altercation to the DON, but could not recall the day and/or time she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 64	21995		

reported it. NA-C stated R15 had argued with her and NA-B about repositioning. NA-C stated R15 did not believe them regarding the times R15 had been last repositioned. NA-C stated R15 verbally cussed at the aides and accused her of yelling. NA-C stated she was trying to give R15 an answer about her repositioning adding she told R15, "You're not taking my answer." Further, NA-C stated she provided R15 a grievance form to fill out with her name on the form before giving it to the resident because "my last name is difficult to spell." NA-C stated R15 called her a "fucking bitch." NA-C stated she told R15 that, "she could be a bitch, but was trying not to be."

During a subsequent interview on 5/31/17, at 4:07 p.m. R15 again explained the altercation that occurred when R15 alleged abuse by facility staff. R15 stated the incident happened on 5/2/17, around 7:00 or 8:00 p.m., after the evening meal, and R15 repeated her concerns about the length of time she was lying in bed in the same position and the need for repositioning. R15 described the altercation as an argument with NA-C that went back and forth and escalated. When asked how R15 felt in NA-C's presence now, R15 stated, "nervous and afraid." R15 added she did not like how the incident on 5/2/17, made her feel, and stated, "I felt threatened that night."

R15's progress note dated 5/2/17, authored by (RN)-A at 21:42 (9:42 p.m.) indicated, "NAR [nursing assistant registered] reported to writer that when staff member went to reposition resident, Resident began questioning NAR about repo [repositioning] scheduling. NAR explained to res [resident] that she had just began her shift and repositioned res when she arrived and now, at time of reporting to writer, prior to eve meal scheduling is on time. Res became

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 65	21995		

argumentative with staff member. Staff member assured res that she on time. Res stated 'Why are you arguing with me, you don't have to yell.' Staff member stated, 'I was not yelling or mad, I only told you what I know.' Res replied 'Why are you yelling at me, you are a bitch!', staff member stated she was not angry or yelling. There was another staff member, NAR in the room as well. NAR reporting stated that she will allow res time to become calm and return as res was becoming increasingly agitated and calling Staff member a bitch. Writer went to res room a while after and res is sleeping."

R15's progress note dated 5/4/17, authored by licensed practical nurse (LPN)-B indicated, "Resident will not allow [NA-C] into her room when it was time to repositioning."

Review of R15's progress notes from 5/2/17 to 5/31/17, lacked additional investigation and documentation of the altercation on 5/2/17, or any related follow up to this occurrence.

Facility staff schedules from 5/1/17 to 5/31/17 were reviewed, and indicated the following:
NA-C was scheduled on the following days: 5/2, 5/4, 5/6, 5/7, 5/8, 5/9, 5/13, 5/14, 5/16, 5/19, 5/22, 5/23, 5/25, 5/26, 5/30, and 5/31/17.
NA-B was scheduled on the following days: 5/2, 5/5, 5/6, 5/7, 5/10, 5/11, 5/12, 5/15, 5/16, 5/17, 5/18 5/19, 5/20, 5/24, 5/25, 5/26, and 5/30/17.

When interviewed on 5/31/17, at 5:02 p.m. the DON discussed the altercation which occurred on 5/2/17, between R15 and NA-C. The DON stated the first time she learned of the altercation between R15 and NA-C was "last Thursday" (5/25/17) when NA-C approached her. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 66 stated no staff member had immediately called her. When surveyor reported R15 felt she was "emotionally abused" the DON reacted and stated that was the first "I have heard about this." The DON reviewed the progress notes and acknowledged she did not see any follow up with R15 since the incident, and also stated she did not have someone talk to the resident (R15). The DON stated that had she read the note, she would have talked to the nursing assistants and the resident, "This is what we used to do all the time." The DON added she was unaware NA-C allegedly signed, dated and handed R15 a grievance form about the incident. The DON stated had she known about this, she would have pulled NA-C off the floor, pending an investigation, and also would have talked to the resident. The DON stated, "Call me, I'm on call 24/7". The DON stated she talked to NA-C but did not take it further. She further stated somehow she missed the note. During interview on 5/31/17, at 5:52 p.m. the administrator stated the incident had just been explained to him. The administrator stated R15 had a difficult time with staff, mentioning that R15 recently had a room change and had hard feelings toward him and the DON. In regard to R15's incident on 5/2/17, the administrator stated there might have been a verbal exchange between R15 and NA-C, and it was his understanding they had a disagreement. The administrator stated the DON had talked with NA-C, but, "I would have to talk to [R15] to get her side of the the story." The administrator stated they would put the staff person involved in the allegation on leave during the investigation and replace them, "to protect the other residents," during their investigation. The administrator also stated he would do immediate education	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 67 regarding dignity, patience and resident rights. During a subsequent interview on 5/31/17, at 8:02 p.m. the administrator stated he had just visited with NA-C and suspended her because he just talked with R15, who told me "this staff member made me feel threatened." The administrator stated we would "make things right for [R15]." When interviewed to ensure the IJ removal plan had been implemented on 6/2/17, at 10:43 a.m. LPN-C stated staff was required to complete routine training on various topics, including vulnerable adults and abuse prevention, however, she had not completed it yet for the year. LPN-C stated she had not received any training in the past few days regarding identification of potential abuse, timely reporting of it or how to handle resident allegations of abuse. LPN-C stated if she witnessed or suspected an altercation between staff and a resident and it had potential to be verbal abuse, she would visit with the resident involved and report the situation to the charge nurse or administration. LPN-C stated she was not trained in, nor sure how to handle any staff person involved in a potential altercation as she tried to avoid, "words with the aides." LPN-C stated she had noticed staff interacting with residents before and, "the tone in itself isn't always the nicest," further adding, "The tone around here in general, by staff, is not always the nicest." LPN-C stated she would not immediately remove or suspend a staff member who had allegations of potential abuse made against them as she, "wouldn't feel authorized to do that," and further added the staff, "probably wouldn't listen to me anyway." Further, LPN-C stated she had reported concerns about the tone of staff, "in the past," to the DON and social worker.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 68 A message was left for registered nurse (RN)-A during the survey on 6/1/17, at 1:15 p.m. who did not respond to a telephone call. During a telephone interview on 6/5/17, at 1:16 p.m. RN-A stated she worked with R15 on 5/2/17, and following the altercation, checked on R15 but R15 was sleeping. RN-A stated she checked back and asked R15 what 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 emotional or verbal abuse, however, stated the resident felt safe. RN-A stated she did not document the second conversation she had with R15, and this behavior was typical for R15. RN-A stated [NA-C] "was a favorite" for R15 up until then. RN-A stated she took no further actions, and did not feel any need to call the administrator or DON about this incident. Although the facility acknowledged the altercation between R15 and NA-C on 5/2/17, the facility's inaction to fully identify R15's potential abuse that day and subsequently take steps to ensure the safety of R15 immediately pending any finding, and failed to thoroughly investigate the complaint to make a determination. There was no investigation completed to determine possible abuse, nor did the facility protect other residents as identified by the facility policy. The immediate jeopardy which began 5/2/17, was removed on 6/2/17, at 3:56 p.m. after the facility implemented a removal plan which included: - administrator met with R15, revised the plan of care, and reported the allegation to the State Agency; -placed alleged staff on leave pending the outcome of the investigation; -screened all residents regarding any potential	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 69 abuse; -educated staff on appropriate and timely identification and handling of resident allegations of abuse; -planned to present additional information regarding abuse at an upcoming resident council meeting. - facility designated social services and other staff to conduct random observations during care provision to audit staff, and interview residents to ensure appropriate care is provided. -Additionally, 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	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 70	21995		

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 to the incident" and "corrective action based on the investigation will be completed (e.g., change of procedure, training, discipline or discharge of staff, etc.)"

R24's annual MDS dated 4/19/17, indicated R24 had severe cognitive impairment. The MDS identified R24 needed extensive assistance for bed mobility, transfer and ambulation. The MDS 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 care plan revised on 3/8/17, identified R24 had a potential for falls/accidents. Risk factors included use of medications, pain, a fall 6/14, resulting in an intracranial hemorrhage, resulting in impaired mobility/cognition, impulsivity, and placing him at higher risk for falls. The care plan identified R24 had fallen several more times since the initial fall. A fall mat at the resident's bedside was listed as an intervention. R24's undated Group D nursing assistant sheet identified a floor mat as a safety intervention for R24.

A progress note dated 5/11/17, at 3:13 a.m. indicated R24's bed alarm went off at 1:20 a.m. and staff found him lying on his stomach "on the floor" in a pool of blood. The blood was coming from a laceration on his head.

R24's emergency room discharge report dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 71 5/11/17, indicated the resident received seven sutures to a head laceration. During observation on 5/31/17, at 7:37 p.m. R24 was lying in bed without a fall mat on the floor by the bedside. During interview on 5/31/17, at 7:56 p.m. NA-H stated the fall mat was not on the floor, looked for the fall mat and was unable to locate it. NA-H then left the room and went to help another resident. No floor mat was placed by R24's bedside. During interview on 5/31/17, at 8:06 p.m. trained medication aid (TMA)-A stated R24 needed to have a fall matt at his bedside. During interview on 6/2/17, at 10:33 a.m. the DON reviewed the progress note regarding the the fall dated 5/11/17, and stated it did not look as if the fall mat was on the floor at the time of the fall as care planned. The DON further stated she did not realize until 6/2/17, while reviewing the progress note the resident was found on the floor and not on his fall mat. The DON proceeded to look for the fall investigation and stated it was not completed and there were no further details regarding the fall on 5/11/17. The DON stated when reviewing falls and implementing new interventions the fall investigation sheet was not always reviewed, and this was why she did not know the investigation had not been completed. The DON stated the assessed fall interventions prior to the fall were expected to be followed and if the staff were not following the care plan on 5/11/17, the fall should have been reported to the state agency and thoroughly investigated, per the facility policy.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00933	A. BUILDING: _____ B. WING _____	06/02/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 72 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		