DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KQT6

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: **7** (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)

6. DATE OF SURVEY **11/02/2018** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
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: **A*** (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:
Brenda Fischer, Unit Supervisor — 11/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 11/06/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/03/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 8, 2018

CMS Certification Number (CCN): 245336

Administrator
The Estates At Delano LLC
433 County Road 30
Delano, MN 55328

Dear Administrator:

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 November 1, 2018 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Electronically delivered
November 8, 2018

Administrator
The Estates At Delano LLC
433 County Road 30
Delano, MN 55328

RE: Project Number S5336027 and H5336026

Dear Administrator:

On October 17, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective October 21, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 16, 2018. (42 CFR 488.417 (b))

Also, you were notified on October 17, 2018 that 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 November 16, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on August 16, 2018, that included an investigation of complaint number H5336026, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 2, 2018. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 2, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR completed on October 2, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 2, 2018, as of November 1, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 1, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 17, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 16, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 16, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 16, 2018, is to be rescinded.

In our letter of October 17, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 16, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 1, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KQT6

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: 7 (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 **10/02/2018** (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*** (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:
Michelle Thompson, HFE NE II — 10/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 10/24/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/03/2018
(L33)

DETERMINATION APPROVAL

Electronically delivered

October 17, 2018

Administrator
The Estates At Delano LLC
433 County Road 30
Delano, MN 55328

RE: Project Numbers S5336027 and H5336026

Dear Administrator:

On September 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 16, 2018 that included an investigation of complaint number H5336026. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electrically sent CMS-2567, whereby corrections are required.

On October 2, 2018, the Minnesota Department of Health and on September 28, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 16, 2018. The deficiencies not corrected are as follows:

F641 -- S/S: D -- 483.20(g) -- Accuracy Of Assessments
F656 -- S/S: E -- 483.21(b)(1) -- Develop/Implement Comprehensive Care Plan

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electrically sent CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 21, 2018. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be

imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 16, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 16, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 16, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, The Estates At Delano LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 16, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

The CMS Region V Office will notify you of their determination regarding our recommendations 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.

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
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us

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

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,

- Include electronic acknowledgement signature of provider and date.

If an acceptable PoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 allegation of compliance and/or 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 November 16, 2018 (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 February 16, 2019 (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.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

Electronically delivered October 24, 2018

Administrator
The Estates At Delano LLC
433 County Road 30
Delano, MN 55328

RE: Project Number S5336027

Dear Administrator:

On September 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 16, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 2, 2018, the Minnesota Department of Health and on September 28, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 16, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on August 16, 2018.

However, compliance with the health deficiencies issued pursuant to the August 16, 2018 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 16, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 16, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 16, 2018. You should notify

all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, The Estates At Delano LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 16, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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 [Cycle Start + 6 Months()] (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 electronic 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,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

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 _____	R-C 10/02/2018

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
{E 000}	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 10/01/18 through 10/02/18 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 10/01/18 and 10/02/18 was found to have NOT corrected all the citations issued on the survey exited 8/16/18 and additional citations were issued. Complaint investigation H5336026 tag that were issued during the recertification survey on 8/6/18, has been corrected and is back in compliance. 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.	{F 000}		
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the oral/dental section of the Minimum Data Set (MDS) for identified dental issues for 2 of 3 residents (R23, R28) reviewed for MDS accuracy.	{F 641}	MDS's were modified for affected resident's (R23 and R28) All resident's have the potential to be affected, so resident oral assessments will be compared to MDS coding to ensure	10/29/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/23/2018

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 _____	R-C 10/02/2018

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 641}	Continued From page 1 Findings include: R23's admission Minimum Data Set (MDS) dated 5/22/18, identified R23 had severe cognitive impairment. Section L0200 did not identify R23 any dental problems. R23's MHM Admit/Initial Data Collection V-2 dated 5/16/18, identified R23 had a loose or ill fitting denture. R28's admission MDS dated 7/20/18, identified R28 had severe cognitive impairment. Section L0200 did not identify R23 any dental problems. R28's Oral/Dental Evaluation dated 7/20/18, identified R28 had teeth broken or appears to have carries. During interview on 10/1/18, at 3:42 p.m. registered nurse (RN)-C stated Section L0200 was not accurate for R23 and R28. The facility was aware section L0200 was incorrect for R23 from the results of facility's standard survey and she had not completed a MDS correction for R23. Rn-C was not sure why the correction was not completed. The facility had planned to review residents oral assessments against their MDS with each new quarterly assessment going forward and did not correct all potential residents as the facility plan of correction identified. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/17, included section L: Oral/ Dental Status which identified: "Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth,	{F 641}	accuracy. Education provided to MDS coordinator to ensure that oral/dental section of MDS is accurate. DON or designee will conduct random audits of oral/dental assessments and MDS to ensure accuracy, weekly x 4, monthly x 2, and report to QA 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 _____	R-C 10/02/2018

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 641}	Continued From page 2 or the denture moves when the resident tries to talk."	{F 641}		
{F 656} SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	{F 656}		10/29/18

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 _____	R-C 10/02/2018

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 656}	Continued From page 3 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop person-centered comprehensive care plans for 4 of 4 residents (R28, R100, R11, R300) who did not had a person-centered, comprehensive care plan completed no later than 21 days following admission. Findings include: The facility baseline care plan, MHM Initial/Comprehensive Careplan had a goal date which identified a need to be completed within 48 hours of admission. The assessment contained pre defined areas for ADL function (activities of daily living), mobility/safety, fall risk, visual alteration, communication/hearing, cognition, mood/behavioral health, psychotropic drug use, elimination, comfort/pain, respiratory, anticoagulant, dehydration, diabetes mellitus, IV (intravenous) medication/fluids, hospice, dialysis, advance directives/POLST (physician orders for life sustaining treatment), nutrition/dietary, activities, psychosocial well being/ social services, skin integrity, sleep, infection, cardiovascular, smoking, current physician orders and spots for additional areas as identified. The pre-defined areas had pre-populated goals and interventions with a section for resident specific interventions that could be entered into the	{F 656}	Comprehensive care plans were developed and implemented for affected residents (R28, R11, R100, R300). All residents admitted in the last 90 days will be reviewed for a completed comprehensive care plan. Nursing staff responsible for care planning were educated on completing comprehensive care plans with person-centered goals, measurable goals, and interventions, no later than 21 days following admission. DON or designee will conduct random audits of resident care plans, to ensure completeness with person centered goals and interventions, weekly x 4, monthly x 2, and report to QA 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 _____	R-C 10/02/2018

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 656}	Continued From page 4	{F 656}		

system. Also, there was a section for any updates prior to the target date. The assessment goal areas did not identify measurable goals with specific time frames for review.

R28's admission MDS dated 7/20/18, identified R28 had severe cognitive impairment. The MDS identified R28 needed extensive assistance with ADL's. Further the resident preference section identified it was somewhat important to be involved in decisions regarding her care. R28's MDS identified the following Care Area Assessments (CAA) required a further comprehensive assessment; cognitive loss/dementia, communication, urinary incontinence/ urinary catheter, falls, nutritional status, pressure ulcers, psychotropic drugs, pain and a return to community referral. The CAA's were completed on 7/25/18.

R28's MHM Initial/Comprehensive Careplan dated 7/13/18, identified a goal date of 7/15/18 identified resident care needs for ADL's mobility/safety, fall risk, visual altercation, communication/hearing, cognition, mood/behavioral health, psychotropic drug use, elimination, comfort/pain, anticoagulant, dehydration, advanced directives/ POLST, nutrition/dietary, activities, psychosocial well being/ social services, skin integrity, sleep, cardiovascular.

The problem areas had pre-populated interventions checked which were not individualized for R28 and did not identify any resident choices or input. There problem areas did not identify person centered measurable goals with specific time frames 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 _____	R-C 10/02/2018

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 656}	Continued From page 5	{F 656}		

resident was progressing towards the goal.

R28's medical record lacked a completed person centered comprehensive care plan to meet R28's preferences and goals, which were measurable to address the resident's medical, physical, mental and psychosocial needs.

R100's MDS dated 9/7/18, identified R100 had intact cognition. The MDS identified R100 needed limited to extensive assistance with ADL's. Further, the resident preference section identified it was very important to be involved in decisions regarding her care. The CAA's required a further comprehensive assessment; ADL function/ rehabilitation potential, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use and pain. The CAA's were completed on 9/13/18.

R100's MHM Initial/Comprehensive Careplan dated 8/31/18, identified a goal date of 9/2/18 and identified resident care needs for ADL's mobility/safety, fall risk, visual altercation, communication/hearing, cognition, mood/behavioral health, psychotropic drug use, elimination, comfort/pain, anticoagulant, dehydration, advanced directives/ POLST, nutrition/dietary, activities, psychosocial well being/ social services, skin integrity, sleep, infection, cardiovascular.

The problem areas had pre-populated interventions checked which were not individualized for R100 and did not identify any resident choices or input. There problem areas did not identify person centered measurable goals with specific time frames to ensure R100

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 _____	R-C 10/02/2018

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 656}	Continued From page 6	{F 656}		

was progressing towards the goal.

R100's medical record lacked a completed person centered comprehensive care plan to meet R100's preferences and goals, which were measurable to address the resident's medical, physical, mental and psychosocial needs.

During interview on 10/1/18, at 3:09 p.m. registered nurse (RN)-C stated the facility used the baseline care plan MHM Initial/Comprehensive Careplan until the resident had their quarterly MDS assessment completed 3 months following admission. At the time of the first quarterly assessment she took the information from the baseline care plan and entered problem areas, specific measurable goals, resident specific interventions in the care plan section of the electronic medical record (EMR). She was not sure what the facility's plan of correction was regarding comprehensive care plans and knew there had been discussions on whether or not to implement a comprehensive care plan in the care plan section with the required comprehensive care plan guidelines or continue to use the baseline care plan and try to keep it updated until the quarterly MDS assessment. She was unsure of the process to follow.

R242's Admission MDS dated 8/06/18, identified R242 had severe cognitive impairment. The MDS identified R242 needed assist of one with ADL's. Further the resident preference section identified it was very important to be involved in decisions regarding his care. R242's MDS identified the following CAA required a further comprehensive assessment: cognitive loss/dementia, communication, urinary

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 _____	R-C 10/02/2018

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 656}	Continued From page 7	{F 656}		

incontinence/ urinary catheter, falls, nutritional status, pressure ulcers, psychotropic drugs, pain and a return to community referral. The CAA's were completed on 8/10/18.

R242's R28's MHM Initial/Comprehensive Careplan dated 7/30/18, identified a goal date of 7/31/18 identified resident care needs for ADL's mobility/safety, fall risk, visual altercation, communication/hearing, cognition, mood/behavioral health, psychotropic drug use, elimination, comfort/pain, anticoagulant, dehydration, advanced directives/ POLST, nutrition/dietary, activities, psychosocial well being/ social services, skin integrity, sleep, cardiovascular.

The problem areas had pre-populated interventions checked which were not individualized for R242 and did not identify any resident choices or input. There problem areas did not identify person centered measurable goals with specific time frames to ensure the resident was progressing towards the goal.

R242's medical record lacked a completed person centered comprehensive care plan to meet R242's preferences and goals, which were measurable to address the resident's medical, physical, mental and psychosocial needs.

During interview 10/02/18, at 9:35 a.m. RN-C stated she completes the MHM Initial/Comprehensive Careplan (baseline careplan) first and then she was directed she had until the quarterly MDS was due to complete the comprehensive full care plan. RN-C stated she had just started working on R242's comprehensive full care plan and thought 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 _____	R-C 10/02/2018

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 656}	Continued From page 8	{F 656}		

had until 11/06/18, when his quarterly MDS was due.

R300's diagnoses, as identified on the resident face sheet with a print date of 10/1/18, included intracerebral hemorrhage, bacteremia, overactive bladder, chronic kidney disease and hypertension. The face sheet indicated R300 was admitted to the facility on 9/2/18. R300's admission Minimum Data Set (MDS) dated 9/8/18, identified the following care area assessments (CAAs) be included in the resident's care plan: cognitive loss/dementia; communication; Activities of Daily Living (ADL) functional/rehabilitation potential; urinary incontinence and indwelling catheter; falls; nutritional status; dehydration/fluid maintenance; dental care; and pressure ulcer. The CAAs were completed 9/14/18.

R300's facility MHM Initial/Comprehensive Care Plan effective 9/3/18, included the identified needs from the care area assessments. R300's care plan goals and specific interventions, for each care area, were identified on the care plan with check marks, chosen from generic, pre-scripted lists for each care area. There were no unique resident-specific goals identified on R300's current care plan. Of the ten assessed care plan need areas, there were six (6) resident-specific interventions narrated on R300 initial/comprehensive care plan. R300's care plan, listed a goal date of 9/3/18. None of the identified care area goals had future, target dates for completion.

During interview on 10/2/18 at 1:43 p.m. the director of nursing (DON) talked about resident care plans, nursing aide care sheets, and how

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 _____	R-C 10/02/2018

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 656}	Continued From page 9	{F 656}		

staff got the information they needed to take care of the residents. The DON acknowledged there were concerns with (R28's R100's, R11's and R300's) care plans, and stated they lacked target dates, were not completely "resident specific" and they were "not caught up with updated care plans." The DON stated the temporary care plan, the one used currently in the electronic record, was "kinda like a nursing report, a baseline," and it was getting the idea in the first twenty-four to forty-eight hours of how to care for our resident, and it's "just a start." The DON stated the comprehensive care plan was the "running, living record" of a resident's stay in the nursing home, and also was the "live, on-going, and personalized" instruction on how to care for the resident, right up to the day the resident is no longer here. The DON stated "moving forward" she and her staff would dive into the care plans, put them on our "Outlook Calendar" to have them ready on day twenty-one and follow the manual. The DON stated simply "Residents should have a comprehensive care plan."

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/17, identified the comprehensive care plan was to be completed no later than 7 days after care area completion, and no later than 21 days following admission to the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KQT6

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 **08/16/2018** (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*** (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:
Jennifer Bahr, HFE NE II — 09/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 10/02/2018 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 4, 2018

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

RE: Project Numbers S5336027 and H5336026

Dear Ms. Schreder:

On August 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. In addition, at the time of the August 16, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5336026 that was found to be substantiated.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 25, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 25, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 November 16, 2018 (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 February 16, 2019 (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 electronic 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

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 _____	C 08/16/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/13/18 to 8/16/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		9/25/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2018

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 _____	C 08/16/2018

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
E 018	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.	E 018		

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 _____	C 08/16/2018

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
E 018	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track the location of on-duty staff and sheltered residents, in the facility's care, during an emergency. This had the potential to affect all 38 current residents in the facility and staff. Findings include: The facility's Emergency and Disaster Plans, updated 11/2017, were reviewed. In the emergency communication plan, there was direction and chain of command for staff in an emergency. However, the plan lacked documentation of a procedure or policy for a system to track residents and staff whereabouts and location in an emergency. When interviewed on 8/16/18, at 3:42 p.m. the facility administrator stated after reviewing the facility's plan, said there was no information or policy regarding how staff and residents would be tracked, if out of the building. The administrator stated if there were procedures or policy, "I don't see one."	E 018	The facility has developed and implemented emergency preparedness policies and procedures that include a system to track the location of on-duty staff and sheltered residents. Staff will be re-educated on the facilities process of tracking the location of on-duty staff and sheltered residents. An audit of 3 staff members' knowledge regarding the policy/procedure for tracking the location of on-duty staff and sheltered residents will be completed weekly x4 weeks, then as needed. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 024		9/25/18

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 _____	C 08/16/2018

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
E 024	Continued From page 3 this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop emergency preparedness policies and procedures, that addressed using volunteers, or other emergent staffing strategies, during an emergency. This had the potential to affect all 38 current residents in the facility. Findings include: The facility Emergency and Disaster Plan, revised 11/2017, was reviewed. The document lacked any policy or procedure regarding the use of any volunteers during an emergency. On 8/16/18, at 3:49 p.m. the facility emergency preparedness program was reviewed with the facility administrator. The administrator said there were policies in place to address staffing, and stated the facility would handle emergencies "only with employees." The administrator stated	E 024	The facility has developed emergency policies and procedures that address using volunteers or other emergent staffing strategies during an emergency. Staff will be educated on volunteers and staffing during an emergency per event policy. An Audit of 3 staff members knowledge regarding the use of using volunteers or other emergency staff strategies during an emergency will be completed weekly x4 weeks, then as needed. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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
E 024	Continued From page 4 he did not see anything in the plan to address volunteers and the use of community people.	E 024		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		9/25/18

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 _____	C 08/16/2018

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
E 039	Continued From page 5 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community and/or individual facility based exercise training program to test their emergency preparedness program. This had the potential to affect all 38 residents who currently resided in the facility, along with staff who work in the facility. Findings include: The facility's Emergency and Disaster Plan policies and procedures, updated 11/2017, were reviewed. The facility provided no evidence that a full-scale drill/exercise and a tabletop exercise had been completed to practice implementation	E 039	The facility will complete 2 table top exercises to test the emergency plan by 9/25/18. Tentatively, table top exercises have been scheduled for 9/19/18 and 9/21/18 with both department head and frontline staff participation. Staff will be re-educated on testing that their emergency plan is completed annually, using a full scale and/or table top exercise. An audit of full scale and/or table top exercises will be completed to ensure	

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 _____	C 08/16/2018

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
E 039	Continued From page 6 of the facility's emergency procedures to test their emergency preparedness plan. On 8/16/18, at 3:49 p.m. the facility emergency preparedness program was reviewed with the facility administrator. During interview, the administrator stated the facility and staff completed monthly fire drills and other weather drills, but there was no large scale or facility wide drill with outside involvement. The administrator stated he was not aware of any testing of the facility's emergency preparedness plan and there had been no test or practice of the emergency plan at least "since I've been here."	E 039	completion annually. Maintenance Director or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	
F 000	INITIAL COMMENTS On 8/13/18 to 8/16/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. In addition, an investigation of complaint H5336026 was completed and substantiated with deficiencies cited at F677, F689, F725 and F921. 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 may be conducted to validate that substantial compliance with the	F 000		

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 _____	C 08/16/2018

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 7 regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		9/25/18

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 _____	C 08/16/2018

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 550	Continued From page 8 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained during morning routine for 1 of 1 residents (R6) reviewed who required extensive staff assistance to complete activities of daily living (ADLs). Findings include: R6's diagnosis, as identified on the Admission Record printed 8/16/18, included dementia. R6's admission Minimum Data Set (MDS) dated 5/29/18, indicated R6 had long and short-term memory problems, had moderately impaired decision-making skills that required cues and supervision. R6's care area assessment (CAA) for ADLs dated 5/29/18 indicated R6 was always incontinent of bowel/bladder and wore briefs. R6's care plan dated 7/27/18 identified R6 required assistance with ADLs and cares, and directed to provide pericare after each incontinence episode R6 was observed on 8/14/18, at 8:22 a.m. in bed in his room lying on his right side, facing the wall, dressed in a gown covering his torso and hips, and wearing an incontinent brief. R6's incontinent brief was soiled, and there was noticeable strong scent of urine in the room. R6's bed mattress was fitted with a sheet, and underneath R6's bottom was an approximately 2' (foot) by 2'	F 550	R6 was reviewed for dignified existence regarding continence cares. Plan of care and interventions have been updated and reviewed to reflect resident□s dignity. R6 plan of care and interventions have been updated to reflect dignified existence. All current residents have been identified for Resident Rights and Exercise to Rights for dignified existence. Resident□s interventions and plan of care have been reviewed and updated. Staff will be re-educated on resident□s dignity along with assuring continence care is completed to promote dignity. Audits will be completed on 10% of the residents in the facility to ensure residents are assisted dignified manner and to ensure compliance. Audits to be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation An audit of 3 current residents, to ensure resident□s dignity is maintained, will be completed weekly x4, and then monthly	

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 _____	C 08/16/2018

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 550	Continued From page 9	F 550		

moisture absorbing pad. The absorbing pad was visibly soiled and wet, and smelled of urine, the moisture and wetness had soaked beyond the edges of the pad, and the surrounding bed sheet were visibly wet. At 9:26 a.m. R6's position on his bed remained unchanged, and R6's brief, still intact and soiled, with the absorbing pad and surrounding bed linens. Nursing assistant (NA)-A walked into R6's room and peered at R6, noted he was asleep, and immediately left the room without assisting him.

R6's continued to remain soiled in the same position with wet incontinent product, absorbing pad and bed linen without being changed at 9:37 a.m., 10:14 a.m., and 10:29 a.m., more than two hours since R6 was first observed lying in bed and soiled at 8:22 a.m. that morning.

On 8/14/18, at 10:56 a.m. nursing assistant (NA)-G entered the room, and assisted R6 with incontinence cares and got R6 dressed. After providing cares, NA-G stated R6's incontinence brief "was soaked" and had a heavy amount of urine, but no BM (bowel movement). R6's bottom was normal in color, there was no redness, and R6 tolerated cleansing of his buttocks without signs of pain or discomfort.

When interviewed on 8/14/18 at 11:03 a.m. NA-G stated R6 was wet, and it was "obvious" you can see the bed was soaked, the pad was wet. NA-G stated R6 was on a turning and repositioning schedule, and R6 would be toileted, at least "every two hours." NA-G stated just recently, there had been a lot of student workers who worked during the summer who recently left, and there had been struggles to get resident cares done "since they left." NA-G stated that R6

x2.

Director of Nursing or designee will be responsible party.

QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.

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 _____	C 08/16/2018

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 550	Continued From page 10 "should have been cleaned up earlier" even if he wanted to remain in bed. When interviewed on 8/16/18, at 9:14 a.m., registered nurse (RN)-A stated it was not right to allow a resident who was wet to remain unchanged, especially if the resident was unable to voice that. RN-A stated it was not ok for R6 to have been laying wet for any extended time, and it was "no good for anybody" to sit around in wet pants. RN-A stated it was not good especially because R6 had skin issues, and "it is a dignity issue." RN-A said he was disappointed and "this should not happen." A facility policy regarding resident dignity was requested, but not provided.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed for 1 of 1 residents (R18), observed self administrating medications of a nebulizer. Findings include: R18's quarterly Minimum Data Set (MDS) of 6/21/18, indicated R18 had severe cognitive impairment and received extensive assistance	F 554	Resident Self-Admin Meds-Clinically Appropriate R18 was reassessed and is not able to self-administer the nebulizer safely. Care plan reviewed and updated to reflect assessment changes and reflect assistance with nebulizer. A facility audit has been completed on all residents to assure self-administration of medications is accurate and administer	9/25/18

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 _____	C 08/16/2018

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 554	Continued From page 11 with activities of daily living, and had diagnoses of dementia, cerebral palsy (a chronic disorder that affects muscle movement), and a pulmonary disorder. R18's care plan initiated on 5/27/18 indicated the potential for alteration in respiratory status related to the diagnosis of chronic obstructive pulmonary disease (obstruction of lung airflow making breathing difficult). The care plan directed staff to administer medications as ordered, response to medications and treatment. The care plan did not indicate resident R18 had been assessed as safe for self-administration of any medication including nebulizer treatment (device for producing a fine spray of medication for inhalation). On 8/16/18, at 8:51 a.m. RN-A was observed passing medications to another unidentified resident. After completing this medication pass, RN-A entered R18's room at 8:54 a.m. R18 was sitting quietly with his nebulizer mask in place and RN-A removed the nebulizer mask. There was no one in the room monitoring R18, while he received the medication via nebulizer. RN-A stated the nebulizer treatment had been administered to R18 and he was now completed with the treatment. On 8/16/18, at 2:04 p.m. RN-A stated he was unaware if a self-administration of medication (SAM) evaluation had been completed for R18. He was told during his orientation that R18 could self-administer his nebulizer after set up. R18's medication administration record (MAR) for August 2018, indicated an order for Pulmicort (a medication used for lung function) 0.25 milligram per two milliliter twice a day.	F 554	safely according to their plan of care. The DON or designee will provide re-education to all appropriate staff on self-administration of medications, to ensure the residents are safe to be left unattended during their nebulizer treatments per Estates at Delano procedures. Audits will be completed The DON or designee will complete audits for 10% of the residents in the facility to ensure residents with self-administration of medication, including nebulizers are administered safe manner and in compliance. This will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation	

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 _____	C 08/16/2018

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 554	Continued From page 12 There was no indication in R18's medical record that an assessment was completed to determine if he was safe to administer his medications. On 8/16/18, at 2:35 p.m. licensed practical nurse (LPN)-A Care Coordinator stated R18 had not been assessed for self-administration of medication. She would expect the nurse administering medications would remain in the room with the resident while receiving nebulizer treatments. On 8/16/18, at 2:59 p.m. the director of nursing stated a physician's order was needed for self-administration of medications and a self-administration of medication evaluation would be required before this would be implemented. The DON stated staff should remain with residents while receiving nebulizer treatments if a SAM evaluation had not been completed and the resident did not have orders in place. A policy for self-administration of medications was requested and not provided.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		9/25/18

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 _____	C 08/16/2018

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 578	Continued From page 13 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 residents (R293) reviewed for Advance Directives, had their current health care wishes identified clearly in the medical record to ensure staff were aware of their wishes. Findings include:	F 578	Resident R293's record has been corrected to show updated advance directive wishes. All resident's records regarding advance directive or POLST have been updated to accurately account for current healthcare wishes.	

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 _____	C 08/16/2018

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 578	Continued From page 14 R293's Order Summary Report for admission date of 8/1/16, indicated R293's code status (The level of medical interventions a patient wishes to have started if their heart or breathing stops) was full code. This indicated life sustaining treatment would be implemented when a resident was found not breathing or if their heart had stopped. A Medicare Hospice Notice of Election Statement for R293's identified R293 enrolled in hospice on 8/9/18. On 8/13/18, 6:20 p.m. R293's record was found to have a POLST (Provider order for life sustaining treatment) , signed by family member (FM)-A, which indicated a change in R293's code status to reflect a wish for DNR (Do not resuscitate) and comfort focused treatment to allow a natural death. This document had not been authenticated by a physician, to reflect the change in code status. R293's progress notes of 8/14/16, at 10:06 a.m. indicated licensed practical nurse (LPN)-A Care Coordinator had spoken with the hospice nurse while in facility who identified she would have the MD (medical director) for the hospice agency sign the current POLST and have this sent to the facility. On 8/14/18, at approximately 1:00 p.m., R293's medical record contained a copy of the current POLST, signed by the physician, and dated 8/9/18 when family requested a DNR status. The electronic time stamp on the fax indicated the fax had been received on 8/14/18, at 10:38 a.m. The physician's orders on the electronic medical record (EMR) continued to identify R293 as a full	F 578	Staff will be re-educated on Advance Directives and the resident's current health wishes. An audit of 3 current residents Advance Directives and their current health wishes will be completed weekly x4, and then monthly x2. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 578	Continued From page 15 code status, and not DNR as the POLST identified. On 8/16/18, at 12:04 p.m. LPN-A Care Coordinator reviewed R293's medical record and verified the residents' code status on the Admission Order Summary of 8/1/18. The physician signature date on the POLST was 8/9/18, but the facility had not received the completed POLST until 8/14/18, after the surveyor brought the information to the facility's attention. On 8/16/18, at 3:02 p.m. the director of nursing (DON) stated orders for code status were reviewed upon admission to the facility and with any changes in conditions and upon request. The DON stated when a POLST was completed and showed a change in health care directive decision. The facility should have these changes clearly identified in the record so staff can follow the resident's wishes. A facility policy was requested for provision of resident directed end of life care through the use of a POLST but was not received.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		9/25/18

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 _____	C 08/16/2018

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 583	Continued From page 16 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy for 1 of 1 resident (R37) observed to have lower body exposure while left in their room alone with the door open and curtain not pulled. Findings include: R37's significant change Minimum Data Set (MDS) dated 7/18/18 identified R37 had diagnoses of Alzheimer's disease, benign prostatic hyperplasia (BPH) with neurogenic bladder and diabetes mellitus. R37's MDS	F 583	R37 was reviewed to assure privacy while in his room. Plan of care and interventions have been updated and reviewed to reflect resident's privacy. All current residents have been identified for privacy while left in their room alone. Resident's interventions and plan of care have reviewed and updated. Staff will be re-educated on resident's privacy during cares. An audit of 3 current residents, to assure	

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 _____	C 08/16/2018

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 583	Continued From page 17 identified R37 had severe cognitive impairment and required extensive assistance with bed mobility, dressing and grooming. R37's current care plan printed 8/16/18 identified R37 had impaired self cares and mobility deficit. R37's care plan included interventions of assistance with dressing, bed mobility and personal hygiene. R37's care plan further identified he had cognitive loss and instructed staff to advocate for him as needed. R37 was observed on 8/16/18, at 8:18 a.m. lying on his back in his bed, with his blue and white hospital gown bunched up at the waist, exposing his lower abdomen, genital area, legs and stockinged feet. R37 had an incontinent pad lying under his buttocks and pulled down between his knees. R37's blanket and sheet were lying next to his right side. R37's door was wide open to the hallway. His curtain was pulled open bunched up covering an area next to the wall and at the foot of his bed approximately 2 feet. R37's supra pubic catheter leg bag was lying next to his outer left thigh. No staff were present in R37's room. At 8:19 a.m. nursing assistant (NA)-A entered R37's room, stood next to R37's bed and began talking on his walkie talkie to nursing assistant (NA)-B. He asked NA-B what she had been doing with R37. NA-A stated NA-B told him R37 had been in the middle of a bowel movement and required two staff to reposition him. NA-A then repositioned R37's incontinent pad over his genital area, then pulled his gown down to cover his abdomen, genital area and thighs, then covered R37 with his sheet and blanket. On 8/16/18, at 8:31 a.m. NA-B stated yes, she had been taking care of R37. NA-B stated she	F 583	privacy during cares, will be completed weekly x4, and then monthly x2. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 583	Continued From page 18 had washed him up, emptied his catheter bag and applied his socks. NA-B stated she was called away across the hall to assist NA-A with a resident who was attempting to transfer herself. NA-B apologized for forgetting to pull R37's privacy curtain and indicated she had left his door open. NA-B denied leaving his gown up with him exposed. NA-B stated privacy was important. On 8/16/18, at 8:36 a.m. the director of nursing (DON) stated she would expect staff who needed to leave a resident during cares, to leave them unexposed and safe. The DON confirmed privacy curtains should be used and resident's doors closed. The DON further stated nursing staff should only expose areas of the body necessary for cares. The DON confirmed resident privacy was very important. On 8/16/18, at 9:27 a.m. the administrator stated there were no policies for activities of daily living or privacy. The administrator indicated nursing staff were to follow resident care plans and the resident bill of rights.	F 583		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the oral/dental section of the Minimum Data Set for identified dental issues for 1 of 1 residents (R23) reviewed for dental concerns.	F 641	R23's MDS has been updated to accurately reflect the resident's dental issues and coded correctly. All current residents will have their most recent MDS review for accuracy of	9/25/18

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 _____	C 08/16/2018

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 641	Continued From page 19 Findings include: R23's admission Minimum Data Set (MDS) dated 5/22/18, identified R23 had severe cognitive impairment and section L0200 did not identify any dental problems. R23's MHM Admit/Initial Data Collection V-2 dated 5/16/18, identified R23 had a loose or ill fitting denture. On 8/14/18, at 3:39 p.m. R23 stated he had a loose lower denture since admission to the facility. When R23 was talking his lower denture moved within his mouth. During interview on 8/16/18, at 9:46 a.m. MDS coordinator, registered nurse (RN)-C stated R23's admission MDS dated 5/16/18, was not accurate. Section L0200A should have been checked, identifying R23 had a loose fitting denture. RN-C stated she was on leave at the time of the assessment and did not know why it was coded inaccurately. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/17, included section L: Oral/ Dental Status which identified: "Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk."	F 641	Section "L" If MDS is not accurate, the MDS will be modified and resubmitted. The DON or designee will provide re-education to all appropriate staff on Section" L" accuracy of assessments. The Comprehensive Assessment Policy has been reviewed and remains appropriate. An audit of two Quarterly or Annual MDS Assessments per week with ARD s in the week will be completed on Section "L" by the MDS Coordinator to assure that the MDS is accurate prior to submission DON or designee will complete audits weekly x4 and then monthly x2 to assure compliance. Audit results will be reviewed by the QAPI Committee for further recommendations. MDS RN and DON will continue to work together to assure that all MDS assessments are accurate and educate nursing staff on the importance of accuracy of all assessments and how they affect the MDS.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		9/25/18

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 _____	C 08/16/2018

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 656	Continued From page 20 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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 _____	C 08/16/2018

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 656	Continued From page 21 section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop person-centered comprehensive care plans within 21 days following admission to the facility for 3 of 6 residents (R20, R242, and R23) who had identified staff needs for assistance with cares. R20's admission Minimum Data Set (MDS) dated 6/26/18, indicated R20 had moderate cognitive impairment and needed extensive assistance from staff with mobility and toileting and was frequently incontinence of bowel and bladder. R20's medical diagnoses included dementia and heart failure. The Pressure Ulcer (PU) Care Area Assessment worksheet, dated 7/2/18, identified R20 was at risk for developing a pressure ulcer related to risk factors of impaired cognition, bowel/bladder incontinence, need for assistance with bed mobility and transfers, and concerns of prolonged sitting or lying. The CAA indicated R20's Braden scale (A scale for predicting pressure ulcer development) placed her at moderate risk for developing a pressure ulcer. R20's Initial/Comprehensive Careplan, effective date 6/20/18 identified R20 had the potential for alteration in skin integrity related to limited mobility. The care plan lacked additional risk factors including Braden scale, impaired cognition, pulmonary and cardiovascular disease. The care plan lacked specific measurable goal, or time frames for skin integrity. On 8/15/18, at 10:10 a.m. registered nurse (RN)-A stated he had not developed the care plans and was unsure who completed care plan	F 656	R20, R242, and R23 Comprehensive Care Plans have been updated to reflect person- centered care. All current residents who have been identified for Comprehensive Care Plans have been reviewed and updated. Staff will be re-educated on Comprehensive Care Plans to reflect person centered care. An audit of 3 current residents to assure the Comprehensive Care Plans have been updated, to reflect the resident person-centered care, will be conducted weekly x4, and then monthly x2. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 656	Continued From page 22	F 656		

development and updates.

On 8/16/18, at 12:15 p.m. licensed practical nurse (LPN)-A, Care Coordinator stated the care plan was developed upon initial admission and reviewed with the residents at their initial care conference which was completed within 21 days from admission. LPN-A, Care Coordinator stated the document titled Initial/Comprehensive Careplan was the current care plan for R20. LPN-A stated the care plans are reviewed on a quarterly basis, and more often as needed to reflect the resident's current needs.

R242's admission Minimum Data Set (MDS) dated 8/6/18, indicated R242 had moderate cognitive impairment with poor decision making skills with cues and supervision for wandering behaviors and had a wander/elopement alarm. The MDS indicated R242 received limited assistance with walking and used a walker and wheelchair. The ADL (Activities of daily living) Care Area Assessment (CAA) worksheet indicated R242 required limited assist of one with ambulation, toileting, and had a history of falls with risks for further decline in general ability. R242's diagnoses included encephalopathy (brain dysfunction due to a medical disorder), and altered mental status.

R242's Initial/Comprehensive Careplan, effective date 7/31/18 indicated R242 had impaired physical mobility related to encephalopathy and weakness. The care plan directed the staff to assist with transfers, walking, and provide assistance for turning, reposition and remind to offload (to relieve pressure) every two hours and as needed (PRN). The care plan indicated staff was to provide weight bearing assistance, even

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 _____	C 08/16/2018

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 656	Continued From page 23	F 656		

though the assessment identified limited assistance. Even though the care plan identified the mobility problem/falls there were no specific measurable goals with identified time frames.

On 8/16/18, at 2:27 p.m. LPN-A, Care Coordinator stated R242's initial care conference was held on 8/14/18. during that time they review the initial care plan, and they make sure it is current and reflective of their needs. They consider this to be their comprehensive care plan, even though there were no specific measurable goals with identified time frames.

On 8/16/18, at 3:09 p.m. the director of nursing stated the care plan goals should be measurable and time specific.

R23's admission Minimum Data Set (MDS) dated 5/22/18, identified R23 had severe cognitive impairment and section L0200 did not identify any dental problems.

R23's MHM Admit/Initial Data Collection V-2 dated 5/16/18, identified R23 had a loose or ill fitting denture. Further, R23 had a upper and lower denture. The section related to dentist name and last visit was blank. The section requiring a dental summary was blank.

R23's MHM Initial Comprehensive Careplan dated 5/16/18, identified R23 had dentures but did not address the lower denture was ill fitting or the need for a dental referral. The care plan directed staff to arrange for dental follow up as needed.

R23's medical record did not identify a comprehensive care plan was developed within

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 _____	C 08/16/2018

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 656	Continued From page 24	F 656		

21 days following admission to the facility to include person centered interventions related to dentist preference and frequency of visits.

On 8/14/18, at 3:39 p.m. R23 stated he had a loose lower denture since admission to the facility. R23 stated he would like to see a dentist about the loose denture. Further, the facility had never offered to arrange dental services for him. When R23 was talking his lower denture moved within his mouth.

During interview on 8/15/18, at 1:06 p.m. registered nurse (RN)-A stated the admitting nurse usually completed the initial resident assessment. RN-A was not aware if R23 was seen by a dentist for his loose dentures. Further, RN-A stated he had observed R23's dentures sliding in and out of his mouth and clicking while he was eating. He did not offer R23 a referral to a dentist.

During interview on 8/16/18, at 9:46 a.m. RN-C stated the nurse completing the oral assessment sections should have completed the assessment and made a referral to dentist to address his loose bottom denture. It was RN-C's stated the managing companies practice was to complete the comprehensive care plan when the facility completed the quarterly assessment about 90 days following admission.

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/17, identified the comprehensive care plan was to be completed no later than 7 days after care area completion and no later than 21 days following admission to the facility.

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 _____	C 08/16/2018

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 677	Continued From page 25	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care for 2 of 5 residents (R6, R1) and failed to ensure resident grooming needs were met for 1 of 5 residents (R23) reviewed for activities of daily living and who were dependent upon staff for assistance. Findings inlcude: R6's diagnoses, as identified on the the Admission Record printed 8/16/18, included dementia with behavioral disturbance, muscle weakness, and pressure ulcer of sacral region, stage 3. R6's significant change Minimum Data Set (MDS) dated indicated he was severely cognitively impaired. R6's care area assessment (CAA) for ADLs dated 5/29/18, indicated R6 was always incontinent of bowel/bladder and wore briefs. The CAA indicated R6 needed extensive, physical assistance for perineal cares, and removal of soiled pad/brief and adjustment of clothing. R6's care plan dated 7/27/18 identified R6 required assistance with ADLs and cares,a and directed to to provide pericare after each incontinence episode. R6's care plan, revised 7/27/18, identified alteration in elimination, and indicated R6 During continuous observation on 8/14/18 from	F 677	R1 and R6 were reviewed for activities of daily living specific to incontinent cares. R23 was reviewed for activities of daily living specific to grooming. Plan of care and interventions have been updated and reviewed to reflect activities of daily living. All current residents' activities of daily living have been reviewed specific to grooming and incontinence care. Resident's plan of care has been reviewed and updated. Staff will be re-educated on activities of daily living including continence care and grooming needs. An audit of 3 current residents to assure the activities of daily living including continence care and grooming needs will be completed weekly X 4, and then monthly X 2. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	9/25/18

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 _____	C 08/16/2018

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 677	Continued From page 26	F 677		

8:22 a.m. to 10:56 a.m. R6 was observed (2 hours and 34 minutes) without the offer of repositioning or toileting. At 8:22 a.m. R6 was observed in his bed in his room, lying on his right side, and facing the wall, dressed in a gown covering his torso and hips, and wearing an incontinent brief. A moisture-absorbing pad (about 2 feet by 2 feet in size) was under R6's bottom. R6's incontinent brief was visibly wet and soiled, and the smell of urine was prevalent in the room. The pad under R6 was also visibly soiled, wet, and smelled of urine, and the wetness had moved beyond the edges of the pad, and onto the surrounding bed sheet which was also wet. R6's position on his bed remained unchanged, and R6's brief, still intact and soiled, as was the absorbing pad and surrounding bed linens until 10:56 a.m., when nursing assistant (NA)-H and NA-G began to help R6 with morning cares, including provided incontinence cares, and subsequently got R6 dressed.

When interviewed on 8/14/18, at 11:10 a.m. NA-G stated R6 was normally on a "two-hour schedule" and he needed to be checked and changed, and that R6 needed to be repositioned too. NA-G stated R6's brief was full, "he was soaked." NA-G stated R6 "should have been" cleaned up earlier, and also he should have been repositioned, but that "we got behind today." NA-G stated in the past week or two there had been a staffing issue and has been a struggle since.

When interviewed on 8/20/18, at 1:36 p.m. licensed practical nurse (LPN)-A stated included in R6's care planned interventions to prevent pressure ulcers included timely repositioning and the cleansing of R6's bottom and peri areas

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 _____	C 08/16/2018

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 677	Continued From page 27	F 677		

following incontinence episodes. LPN-A stated she was disappointed and R6 "should not have been" left unchanged for two hours 34 minutes.

R1's diagnoses , as identified on the Admission Record printed 8/16/18, included dementia with behavioral disturbance, anemia and acute, ischemic heart disease. R1's quarterly Minimum Data Set (MDS) dated 4/20/18 indicated R1 was severely, cognitively impaired. The care area assessment (CAA) for activities of daily living (ADLs) dated 8/8/18 indicated R1 required extensive assist of two with bed mobility and transfers; and was always incontinent of bladder and frequently incontinent of bowel. The CAA for urinary incontinence indicated R1 required extensive assist of one staff for toileting needs, and R1 was always incontinent of bladder, and was at risk for skin breakdown. The CAA indicated R1 received a medication Lasix (a diuretic medication) daily to treat edema. The CAA indicated staff assisted with incontinence care after each episode, and that at times resident will refuse cares when attempting to assist. The CAA also indicated R1 had recurrent open are to left groin related too moisture. R1' care plan identified alteration in elimination of bladder and listed interventions including: to assist as needed with toileting every 2 1/2 to 3 hours; that resident often refuses to allow staff to assist with incontinence care, and staff to reapproach and offer assisting with incontinence cares.

During continuous observation on 8/15/18, beginning at 5:36 a.m. R1 remained lying in her bed, smelling of urine, until staff assisted with morning cares at 8:49 a.m. total of 3 hours 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 _____	C 08/16/2018

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 677	Continued From page 28	F 677		

13 minutes. Nursing assistant (NA)-E entered R1's room at 8:49 a.m. to provide incontinence and routine morning cares, and resposition and assist R1 out of bed. When NA-E removed R1's incontinent product, NA-E described the brief as having "moderate" amount of urine, and when she tossed it in the trash, one could hear it thump when brief hit the bottom of the trash can. R1's skin was observed, and had normal color without redness or observed open areas. R1's brief was heavily saturated with urine. Following cares NA-E assisted R1 into her wheel chair and later into the dining room for breakfast.

During interview on 8/15/18, at 10:09 a.m. NA-E stated she helped R1 with morning cares "about 9 o'clock" and stated she did not know when R1 had last been changed, or repositioned from the night shift. NA-E stated R1 was probably helped "behind schedule." NA-E acknowledged and stated R1 had strong smell of urine when she came to do cares, and R1 was wet. NA-E stated R1 needed "full assistance" with ADLs, including toileting and repositioning, and added R1 was on a toileting schedule which she described as "check and change" and that needed to be done every couple of hours.

When interviewed on 8/21/18, at 12:13 p.m. the wound nurse practitioner stated "It is still important" that all residents who have or are at risk for pressure ulcers "be kept clean, dry and be repositioned." The NP stated those basic interventions "still needed to be done" to prevent further breakdown and irritation."

R23's admission Minimum Data Set (MDS) dated 5/22/18, identified R23 had severe cognitive impairment and required extensive assistance

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 _____	C 08/16/2018

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 677	Continued From page 29	F 677		

with personal hygiene.

R23's MHM Initial Comprehensive Careplan dated 5/16/18, identified R23 had a self care deficit related to end stage renal disease and weakness. The care plan identified R23 would be clean and well groomed and needed assistance for grooming.

During observation on 8/14/18, at 9:12 a.m. nursing assistant (NA)-B wheeled R23 from his room to the dining room for breakfast. R23's hair was not brushed. It was flat in the back and sticking up on the top of his head.

During interview on 8/14/18, at 3:39 p.m. R23 stated NA-B got him ready that morning and did not brush or offer to brush his hair before going to the dining room. R23 did not ask NA-B to brush his hair because she so busy and rushed. "She was so "frazzled" he didn't want to mention it to her. R23 stated he would prefer to go to the dining room with combed hair and he could not comb his own hair.

During interview on 8/15/18, at 12:44 p.m. NA-C stated R23 stated combing a residents hair was a part of cares and R23's hair should have been combed prior to going to the dining room. The staff working with R23 the day before were new and unfamiliar with resident routines and were getting behind with cares.

During interview on 8/15/18, at 1:06 p.m. registered nurse (RN)-A stated R23's hair should have been combed prior to going to the dining room. It was "disappointing" cares were late or not being done by the nursing assistants. Due to the limited number of regular staff the facility

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 _____	C 08/16/2018

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 677	Continued From page 30 hired a pool staffing agency and the pool staff were not familiar with the resident routines and were falling behind on cares. During interview on 8/16/18, at 11:35 a.m. the director of nursing (DON) stated she expected residents to be well groomed in common areas and for staff to assist them with grooming if needed.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the 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 implement care-planned interventions to promote healing and comfort and prevent the worsening a pressure ulcer for 4 of 4 residents (R4, R6, R1 and R20) reviewed who had current pressure ulcers or were identified as at risk for pressure ulcers. Findings include:	F 686	R4, R6, R1, and R20 were reviewed and assessed for risk of pressure ulcers. R4, R6, R1, and R20 plan of care and interventions have been updated to reflect pressure ulcer interventions. All current residents who have been identified for pressure ulcers or at risk for pressure ulcers, their assessments, interventions and plan of care have	9/25/18

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 _____	C 08/16/2018

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 686	Continued From page 31 Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage I pressure ulcer (An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.) Stage II pressure ulcers (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.) Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) Deep Tissue Pressure Injury (DTPI): Persistent	F 686	reviewed and updated to reflect pressure ulcer interventions. All current residents who have been identified for pressure ulcers, interventions, and plan of care have been reviewed and updated. Staff will be re-educated on comprehensive assessments/re-assessments and pressure ulcer interventions to reduce risk of skin breakdown. An audit of 3 current residents with pressure ulcers for comprehensive skin assessment and proper pressure ulcer interventions will be conducted weekly x4, and then monthly x2. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 686	Continued From page 32 non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury R4's quarterly Minimum Data Set dated 5/1/18, identified R4 was cognitively intact and required extensive assistance with bed mobility. The MDS identified diagnoses of diabetes and multiple sclerosis. R4 had a Stage 2 pressure ulcer that was present upon readmission to the facility and received pressure ulcer care. R4's pressure ulcer Care Area Assessment (CAA) dated 2/14/18, identified R4 was at risk for development of pressure ulcers and did not currently have a pressure ulcer. R4 had a pressure reduction mattress, a wheelchair cushion and was on a turning and repositioning schedule and frequently refused repositioning. R4's MHM Weekly Pressure Wound Evaluation was completed weekly from 5/17/18 until 8/13/18. The 5/17/18, evaluation was completed upon a hospital return identified R4 returned from the hospital with a new unstageable pressure ulcer.	F 686		

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 _____	C 08/16/2018

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 686	Continued From page 33	F 686		

The previous stage 2 pressure ulcer identified on the 5/1/18, MDS was healed. The assessments included characteristics and measurements of the pressure ulcer, current treatments, and new interventions, whether there were improvements or worsening of the pressure ulcer and notifications to the physician and family. R4 was provided education weekly regarding her refusals to reposition.

MHM Weekly Pressure Wound Evaluation dated 8/14/18, identified R4's returned from the hospital on 8/13/18, and had surgical debridement to R4's coccyx pressure ulcer. The pressure ulcer measured 5 centimeters (cm) x 3.1 cm x 3.1 cm and was identified as unstageable; although description of the wound bed identified tendons present in the middle of the wound identifying the pressure ulcer as a Stage 4. R4 was educated on the risk versus benefits of refusing to reposition and identified new interventions of repositioning every 1-2 hours and removing the lift sling while in her wheelchair

R4's MHM Tissue Tolerance Observation (Sitting) dated 8/13/18, identified R4 had an "open" area on R4's bottom. R2's was identified to require repositioning every 2 hours. MHM Tissue Tolerance Observation (Lying) dated 8/14/18, identified a coccyx wound was identified to require repositioning every 2 hours.

R4's care plan revised 8/13/18, identified R4 was at risk for skin breakdown related to R4's impaired mobility, was wheelchair bound, did not ambulate, sat for extended periods of time, and impaired range of motion to her lower extremities. R4 currently had a pressure ulcer upon return from the hospital on 5/17/18. The care plan did

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 _____	C 08/16/2018

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 686	Continued From page 34	F 686		

not identify a turning and repositioning frequency for R4. R4's care plan did not identify new interventions of repositioning every 1-2 hours and removing the lift sling while in her wheelchair, identified in the 8/14/18, pressure ulcer assessment. The care plan identified risk versus benefits had been provided to R4 and her spouse regarding refusals to reposition.

R4's undated, aid sheet directed staff to reposition R4 every two to two and half hours. The aid sheet did not identify the updated interventions of repositioning every 1-2 hours and removing the lift sling while in her wheelchair, identified in the 8/14/18, pressure ulcer assessment.

On 8/13/18, at 7:12 p.m. R4 was observed seated in a tilted wheelchair in her room on a pressure reducing cushion. R4 stated she had a pressure ulcer on her bottom and had been seated in her wheelchair since she returned from the hospital that day in the early afternoon. Further, staff had not offered to reposition her. R4 stated she was supposed to be repositioned every two hours when she was sleeping but the staff did not always reposition her.

During observation on 8/15/18, at 5:33 a.m. R4 was sleeping on her right side on a full air mattress in her room.

During interview on 8/15/18, at 5:40 a.m. nursing assistant (NA)-J stated R4 was turned and repositioned every two hours at night as she had a pressure ulcer. R4 was last repositioned at 4:30 a.m.

On 8/15/18, at 6:17 a.m. NA-J was giving verbal

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 _____	C 08/16/2018

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 686	Continued From page 35	F 686		

report, at shift change, to NA-H. NA-J did not tell the NA-H R4 was last repositioned at 4:40 a.m.

On 8/15/18, at 8:20 a.m. NA-J was seated in the dining room assisting residents to eat. NA-J stated R4 was to be repositioned every two to three hours and she did not get up for the morning until around 10:00 a.m. NA-J stated she had not repositioned R4 that morning and did not know when she was last repositioned. NA-J then asked for staff assistance to help reposition R4

On 8/15/18, at 8:22 a.m. R4 continued to lie in the same position in bed since continuous observations began at 5:33 a.m. Staff did not offer to reposition R4 during this time. R4 was awake and stated staff had not repositioned her since she went to bed around midnight.

At 8:24 a.m. the director of nursing (DON) and NA-I entered R4's room to assist R4 to reposition. DON and NA-I turned R4 and there was a foam dressing intact on her coccyx. There were multiple red areas on her buttocks that were blanchable. The redness faded and there were no new pressure ulcers observed. R4 requested to stay in bed until after 10:00 a.m.

The DON stated the wound care nurse would be at the facility at 1:00 p.m. to change R4's dressing to her pressure ulcer and assess the ulcer. Further, R4 frequently refused repositioning and risk versus benefits had been provided to R4 and R4's husband multiple times. However, the staff were to make attempts to reposition R4 every two hours and report to the nurse when R4 refused to be repositioned. It was very important to reposition R4 to prevent the current pressure ulcer from worsening and prevent new pressure

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 _____	C 08/16/2018

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 686	Continued From page 36	F 686		

ulcers from developing.

On 8/15/18, at 12:57 p.m. NA-C stated R4 was transferred to the hospital because she was not feeling well.

On 8/16/18, at 8:19 a.m. R4 continued to be hospitalized and R4's pressure ulcer was not able to be observed.

During interview on 8/16/18, at 10:06 a.m. the care coordinator, licensed practical nurse (LPN)-A stated R4 had a history of acquiring pressure ulcers. The pressure ulcer identified in the quarterly MDS dated 5/1/18, had healed. Her current pressure ulcer was developed during a hospitalization in May of 2018. The pressure ulcer was assessed weekly by the wound care nurse. The current pressure ulcer was located on her coccyx. During her most recent hospital stay, her pressure ulcer was debrided and was currently a Stage 4 pressures ulcer. Current interventions included R4 receiving pressure mapping with a specialized cushion for her wheelchair along with a tilt and space wheelchair. She had an air mattress on her bed along with a repositioning program and nutritional supplements to aid with healing. LPN-A stated the tissue tolerance assessments identified when a resident was supposed to be repositioned and should be reflected accurately on the care plan. LPN-A needed to leave the facility on 8/14/18, and did not get a chance to update R4's care plan with the new interventions identified in the wound assessment on 8/14/18.

R6's diagnoses, as identified on the the Admission Record printed 8/16/18, included dementia, muscle weakness, and pressure ulcer

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 _____	C 08/16/2018

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 686	Continued From page 37	F 686		

of sacral region, stage 3, and lymphoma (cancer of the lymph nodes and lymphatic system). R6's admission Minimum Data Set (MDS) dated 5/29/18, indicated he was severely cognitively impaired. R6's care area assessment for pressure ulcers (CAA) dated 5/29/18, indicated R6 was always incontinent of bowel/bladder and wears pad/brief. The CAA indicated R6 required extensive assistance for toilet use, peri (perineal) cares and adjustment of clothing. The CAA further indicated R6 had a stage 3 pressure ulcer o his coccyx, and risk factors for the development of pressure ulcers included R6's needs for assistance with bed mobility and ADLs (activities of daily living), R6's lying and sitting for extended periods, and impaired cognition. R6's CAA for pressure ulcers directed turning/repositioning and off-loading with each routine cares and every 2 hours as needed.

During continuous observation on 8/14/18, from 8:22 a.m. to 10:56 a.m. (2 hours and 34 minutes) R6 was not offered repositioning or toileting.

-At 8:22 a.m. R6 was observed in his bed in his room, lying on his right side, and facing the wall, dressed in a gown covering his torso and hips, and wearing an incontinent brief. A moisture-absorbing pad (about 2 feet by 2 feet in size) was under R6's bottom. R6's incontinent brief was visibly wet and soiled, and the smell of urine was prevalent in the room. The pad under R6 was also visibly soiled and wet, and smelled of urine, and the wetness had moved beyond the edges of the pad, and onto the surrounding bed sheet was also wet. At 9:26 a.m. R6's position on his bed remained unchanged, and R6's brief, still intact and soiled, as was the absorbing pad and surrounding bed linens. and nursing assistant

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 _____	C 08/16/2018

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 686	Continued From page 38	F 686		

(NA)-A walked into R6's room and peered at R6, noted he was asleep, then left the room.

-At 9:37 a.m. there was no change in R6's position, and the wet incontinent product, absorbing pad and soiled linen still present.

-At 10:14 a.m. there was no change in R6's position, and the wet incontinent product, absorbing pad and soiled linen still present.

-At 10:29 a.m. there was no change in R6's position, and the wet incontinent product, absorbing pad and soiled linen still present.

R6's position and lying in the urine-soaked bed remain unchanged from 8:22 a.m. until 10:56 a.m., (2 hours and 34 minutes), when nursing assistant NA-G entered the room, and assisted R6 with morning cares. NA-G removed R6's garment to hold the incontinent brief in place, and removed R6's brief, which was visibly wet, odorous, and saturated. NA-G subsequently provided incontinence cares, during which time R6's bottom was observed. At 11:02 a.m. the hospice registered nurse (HRN) entered the room. In the presence of the surveyor, HRN and NA-G, R6's bottom was observed. R6's bottom was normal in color, there was no redness, and R6 tolerated cleansing of his buttocks without signs of pain or discomfort. The HRN described the size of R6's coccyx open area as "about 1/2" (inch) by 3/8" with minimal depth," and further stated the wound was undressed, skin was intact, normal in color, without sign of inflammation. The HRN stated the pressure ulcer had "stabilized," and should signs of improving, and added R6's pressure ulcer was followed weekly by a wound care nurse. NA-G completed getting R6 dressed.

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 _____	C 08/16/2018

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 686	Continued From page 39	F 686		

When interviewed on 8/14/18, at 11:10 a.m. NA-G stated R6 was normally on a "two-hour schedule" and he needed to be checked and changed, and that R6 needed to be repositioned too. NA-G stated R6's brief was full, "he was soaked." NA-G stated R6 "should have been" cleaned up earlier, and also he should have been repositioned, but that "we got behind today." NA-G stated in the past week or two there had been a staffing issue and has been a struggle since.

During a subsequent, continuous observation on 8/15/18, from 5:35 a.m. to 8:06 a.m., (2 hours and 31 minutes), and R6 was observed seated in a Broda-style wheel chair (a larger chair which can be reclined), without being assisted or offered to repositioning.

-At 5:35 a.m. R6 was near the nursing station seated in a Broda-style wheel chair and was moving in the chair, causing it to slightly rock back and forth. When interviewed at this time, nursing assistant (NA)-J stated R6 was somewhat restless over the night and appeared ready to get out of bed, and so we got him up and dressed "around 4:30 or so" and had been up in his chair at least an hour already.

-At 5:49 a.m. R6 indicated he had pain, pointing to his neck/shoulder area, making a grunting noise while he exhaled. Registered nurse (RN)-B offered an ice pack to place on his neck, which R6 declined, but when asked if he wanted coffee, R6 responded "I'd love that with some sugar." R6 remained seated in the Broda chair, now drinking coffee.

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 _____	C 08/16/2018

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 686	Continued From page 40	F 686		

-At 6:22 a.m. registered nurse (RN)-C wheeled R6 toward his room, and asked if he'd like to lie down before breakfast, to which he declined, and RN-C returned R6 to the day room area, where staff brought him more coffee R6 remained seated in the chair, in the day room,

-At 7:08 a.m. RN-C wheeled R6 into the dining room, and got him Cheerios cereal at 7:08 a.m. Staff offered and gave R6 a second bowl of cereal at 7:28 a.m., which he quickly consumed, all the R6 while remained seated in the Broda chair.

At 8:06 a.m. nursing assistant (NA)-D transported R6 from the dining area into R6's room, where she was jointed by NA-G and together transferred R6 from the Broda chair into his bed to off load and check R6 for incontinence. NA-D removed R6's brief, and described he had "moderate amount" of urine without BM (bowel movement) in his brief. Inspection of R6's bottom was made, and his pressure ulcer was visible. The pressure ulcer located on R6's coccyx, was approximately one-half by on-quarter inch in size, with no visible depth, and R6's bottom was normal in color, without redness.

When interviewed at 8:06 a.m. NA-D stated R6 needed to be checked and repositioned on a schedule of 2 hours, and we probably got off schedule today because R6 was up from the night. NA-D stated she thought R6 was up "around 5" this morning. NA-D stated she did not know when R6 was last off-loaded or repositioned, and that R6 probably "should have been repo' d (repositioned) sooner."

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 _____	C 08/16/2018

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 686	Continued From page 41	F 686		

When interviewed on 8/16/18 at 10:30 a.m. registered nurse (RN)-A stated stated he tried to be on top of when R6 needed to be repositioned or off loaded, that he is in the hall and by being in the hall and present to help out. RN-A stated it was difficult to maintain a tight schedule, especially with the changes in staff, the pool (temporary) staff. RN-A stated that while he thought the care the temporary staff provided residents was good, "it takes time" to get to know the needs of the resident, like turning schedules, and that does not happen overnight. RN-A stated it was not acceptable and "totally not right" that he was not off loaded after being up in his chair for a long time. RN-A stated R6 should be off loaded, and changed position at least every couple of hours.

When interviewed on 8/20/18, at 1:15 licensed practical nurse (LPN)-A stated she follows R6 and rounds with the nurse practitioner, who monitors R6's current pressure ulcer. LPN-A stated R6 was admitted to the facility with the stage 3 pressure ulcer, and has had it "since 2015." LPN-A stated R6 was at the nursing home for pain management of the anal fistula, and has had history of recurring infection. LPN-A stated the NP's assessment of the pressure ulcer is that it will not heal due to his condition, stating R6 was on hospice, and the goal for R6 was comfort focused and to prevent the pressure ulcer from getting bigger and prevent infection. LPN-A stated intervention for R6 in that regard included repositioning and ensuring R6 was cleaned and dry after each incontinence episode. LPN-A stated R6 "should not have been let wet" for any extended period of time and R6 needed to be repositioned and that should be "at least every two hours."

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 _____	C 08/16/2018

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 686	Continued From page 42	F 686		

A Weekly Pressure wound Evaluation dated 2/19/17, identified R6 had a coccyx wound, described as a pressure wound, stage 3, measuring 1.0 cm (centimeters) length x (by) 0.2 cm width x 0.2 cm depth. A review of R6's Integrated Wound Care Progress Notes from 6/6/18 to 7/25/18 indicated the following:

-7/25/18,Wound is Coccyx, chronic stage 3 pressure injury pressure ulcer and has received status of not healed. Subsequent wound measurements are 1 cm (centimeter) length x (by) 0.4 cm width x 0.3 cm depth, with an area of 0.4 sq (square) cm and volume of 0.12 cubic cm. there is no drainage noted, no odor. The patient reports wound pain of level 0/10. The wound is improving. The periwound (area surrounding the wound) is normal. The periwound skin moisture is normal. The periwound skin color is normal. The temperature of the periwound skin is WNL (within normal limits). Periwound skin does not exhibit signs or symptoms of infection. General notes: chronic, long standing, Will likely not heal s/t (secondary to) epically (rolled wound edges) and chronic. Goal is to prevent further progression and infection.

-6/22/18; [R6] readmitted to facility on 4/27/18, on hospice. Ongoing chronic stage 3 pressure ulcer, wound has been present since February 2017. Patient has additional comorbidities which include dementia, history of transient ischemic attack, cerebral infarction without residual defects, type 2 diabetes with neuropathy. Wound is coccyx chronic stage 3 pressure injury and has received status of not healed. Subsequent wound measurements 0.9 cm length x (by) 0.3 cm width and 0.3 cm depth, with an area of 0.27 sq

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 _____	C 08/16/2018

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 686	Continued From page 43	F 686		

(square) cm (centimeters) and volume of 0.081 cc (cubic centimeters). There is no drainage and no odor. The patient reports a wound pain of 0/10. The wound is improving.

-6/14/18; coccyx chronic stage 3 pressure injury; status not healed. Measurement 1 cm length x 0.5 cm width x 0.4 cm depth, area of 0.5 sq cm and volume of 0.2 cc; no draining; no odor; no change in wound progression. Assessment notes: chronic, long standing. Measurements variable dependent on positioning at time of assessment. Will likely not heal s/t epiboly (rolled wound edges) and chronicity. Goal is to prevent further progression and infection.

-6/20/18; coccyx chronic stage 3 pressure injury; status not healed. Measurement 0.9 cm length x 0.5 cm width x 0.4 cm depth, with an ara of 0.45 sq cm and volume of 0.18 cc; no drainage; no odor. Periwound (surrounding) kin texture, moisture, color normal and temperature WNL (within normal limits). Periwound does not exhibit signs of symptoms of infection.

-6/27/18; coccyx, chronic state 3 pressure injury; status, not healed; measurements: 1 cm length x 0.5 cm width x 0.3 cm depth and area of 0.5 sq cm and volume 0.15 cc; no change in wound progression.

-7/3/18; coccyx, chronic stage 3 pressure injury; not healed; 0.8 cm length x 0.4 cm width x 0.2 cm depth, with area of 0.32 sq cm and volume of 0.064 cc; no drainage noted, no odor; there is no change in wound progression.

-7/11/178; coccyx wound, chronic stage 3 pressure injury; not healed; 1 cm length x 0.5 cm

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 _____	C 08/16/2018

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 686	Continued From page 44	F 686		

width x 0.3 cm depth, with an area of 0.5 sq cm and volume of 0.15 cc; no drainage or odor; no noted change in wound progression.

-7/18/18; coccyx, chronic stage 3 pressure injury; not healed; 1 cm length x 0.5 cm width x 0.3 cm depth, with an area of 0.5 sq cm and volume of 0.15 cc. No drainage or odor, and no change noted in the wound progression.

When interviewed on 8/21/18, at 12:13 p.m. nurse practitioner (NP) said she has worked with R6 since May 2017 and stated R6's wound was a Stage 3, chronic pressure ulcer. The NP stated R6's wound was stable, has not healed, and will not heal "due to his comorbidities" and epiboly, or the the wound's "rolled edges". NP stated if the wound were to close now, it would actually increase the likelihood of infection, and the goal no is to prevent wound from increasing and prevent infection. The NP stated the wound is a small open area, less than a centimeter in size, with minimal depth, and there was no tunneling, undermining, odor, and added R6's wound has actually shown improvement. NP stated "It is still important" that all residents who have or are at risk for pressure ulcers be kept clean, dry and be repositioned. The NP stated those basic interventions "still needed to be done" to prevent further breakdown and irritation."

R1's diagnoses, as identified on the Admission Record printed 8/16/18, included dementia with behavioral disturbance, anemia and acute, ischemic heart disease. R1's quarterly Minimum Data Set (MDS) dated 4/20/18, indicated R1 was severely, cognitively impaired. The care area assessment (CAA) for activities of daily living

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 _____	C 08/16/2018

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 686	Continued From page 45	F 686		

(ADLs) dated 8/8/18 indicated R1 required extensive assist of two with bed mobility and transfers; and was always incontinent of bladder and frequently incontinent of bowel. The CAA indicated R1 was at risk for pressure ulcers. The CAA for pressure ulcers identified R1 as at risk for the development of pressure ulcers due to requiring extensive assist with bed mobility, sits and lies for extended periods of times, which was further complicated by R1's refusal of cares from staff when incontinent. The CAA also indicated staff assist R1 to turn and reposition as resident allow, as R1 often refuses cares. R1's care plan identified R1's risk for skin breakdown, and directed, among other interventions: turn and reposition every 2 1/2 to 3 hours.

On 8/15/18, beginning at 5:36 a.m., and for more than 3 hours, R1 was observed lying in her bed, room darkened, TV was playing, as R1 lied on her left side, facing the exit side of the bed toward the room exit. The smell of urine was prevalent near R1 and a pervasive, heavy, moist scent of urine was present throughout R1's room.

-5:36 a.m. R1 observed lying in her bed, covered with a light blanket, the room darkened, with the TV playing; R1 was lying on her left side, facing the exit side of the bed. The smell of urine was prevalent in the room.

-6:13 a.m. no changes in R6's position; room smells humid and moist. TV continues playing, and R6 moved he head slightly toward her shoulder.

-6:27 a.m. R1 same no positional changes.

-6:58 a.m. R1 same no positional changes.

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 _____	C 08/16/2018

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 686	Continued From page 46	F 686		

-7:07 a.m., same no changes (1 1/2 hours of continuous observation)

-8:31 a.m. R1 begins stirring, still laying in same position and yells out "somebody come in here please, will somebody come in here when they have the time, please?" and then repeats the requests three more times. R1's call light was not activated, and there were no staff present in the hallway.

-8:39 a.m., registered nurse (RN)-G walked past R6's room, and heard R1 yell out "Somebody come help me!" RN-G entered the room and told R6 her name. R6 stated and asked "I'm all mixed up....what is today?....I haven't eaten yet." RN-G began talking with R1 for a couple of minutes, activated R1's call light, then reassured R1 help was on the way. RN-G stayed a few more minutes, then informed nursing assistant (NA)-E of R6's needs and desire to arise.

At 8:49 a.m., 3 hours and 13 minutes since the start of observation, NA-E entered R1's room, began to interact and started morning cares. During provision of cares NA-E repositioned R1 and removed the incontinence product, which appeared full. R1's buttocks and coccyx area was observed and the skin was of normal color, and intact. R6 winced as NA-E cleansed her bottom. NA-E completed care, dressed R1 and later wheeled R1 in her wheel chair into the dining area for breakfast.

During interview on 8/15/18, at 10:09 a.m. NA-E stated she helped R1 with morning cares "about 9 o'clock" and stated she did not know when R1 had last been changed, or repositioned from 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 _____	C 08/16/2018

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 686	Continued From page 47	F 686		

night shift. NA-E stated R1 was probably helped "behind schedule." NA-E acknowledged and stated R1 had strong smell of urine when she came to do cares, and R1 was wet. NA-E stated R1 needed "full assistance" with ADLs, including toileting and repositioning, and added R1 was on a toileting schedule which she described as "check and change" and that needed to be done every couple of hours.

R1's Weekly Skin Inspection dated 8/15/18, indicated R1 had no current pressure-related skin issues.

When interviewed on 8/16/18, at 10: 26 a.m. registered nurse (RN)-A stated R1 was on a toileting and repositioning schedule, and added that R1 was more vocal and you could get yelled at by her when you go to check and change. RN-A stated it was difficult to get the turning, repo, the toileting done with the pool staff, because they are unfamiliar with the residents. RN-A stated he thought the aide get the turning done, but done late "and it should not be" because there are residents at risk for skin breakdown and pressure ulcers. RN-A stated R1 was definitely at risk, and "That is not good."

A policy regarding the implementation of resident care plans, provision of incontinence care, and timely repositioning was requested, but none provided.

R20's admission MDS date 6/26/18 indicated R20 had moderate cognitive impairment and required extensive staff assistance with activities

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 _____	C 08/16/2018

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 686	Continued From page 48	F 686		

of daily living (ADL's), incontinent of bowel and bladder, was at risk for pressure ulcer development and had no skin issues. R20's medical diagnoses included dementia and heart failure.

The Pressure Ulcer Care Area Assessment worksheet, dated 7/2/18, identified R20 was at risk for developing a pressure ulcer related to impaired cognition, bowel/bladder incontinence, assistance with bed mobility, transfers. There were concerns of R20 sitting or lying for extended periods of time. The Braden scale (scale for predicting pressure ulcer development) identified R20 was a moderate risk for developing a pressure ulcer.

R20's Tissue Tolerance (TT) Observations (sitting) dated 6/20/18, identified no concerns after sitting two hours and indicated R20 was to be repositioned every two and a half hours while sitting. R20's TT observation (Lying) dated 6/20/18, indicated no concerns after lying two hours and indicated R20 was to be turned and repositioned every two and a half hours while lying. Although the evaluations were completed after two hours of sitting and lying, and the recommendation was to turn and reposition every two and a half hours, even though the assessment identified 2 hours.

R20's nursing assistance care sheets (instructions to care for each resident), undated, indicated R20 was to be repositioned every two and a half to every three hours, which was not consistent with the assessment.

R20's Initial/Comprehensive Careplan effective 6/20/18, identified R20 exhibited impaired

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 _____	C 08/16/2018

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 686	Continued From page 49	F 686		

physical mobility related to generalized weakness/advanced age and required staff assistance with mobility every two hours and as needed. The care plans also identified R20 was at risk for alteration in skin integrity related to impaired mobility and directed staff to assist to turn and reposition every two and a half to three hours. Even though the interventions were not consistent with the TT assessments for R20.

On 8/15/18, at 7:13 a.m. R20 was observed during personal cares provided by nursing assistant (NA)-C. R20 had a area approximately 2 cm in diameter under her right gluteal fold which was pink, with no open areas. NA-C stated R20 had no redness or breakdown previously and this could be an irritation with the incontinence brief. NA-C pushed down the the skin below the right gluteal fold, upon release of pressure, the area became pink, identifying return of good blood flow to an area. NA-C transferred R20 to the wheelchair and went to the dining room for breakfast at 7:20.

At 7:20 a.m. R20 was continually observed while in breakfast and went to the dayroom to watch television. R20 remain seated in her wheelchair until 10:03 a.m., a total of 2 hours and 43 minutes without being repositioned. At 9:52 a.m. the surveyor notified staff of R20 not being repositioned timely. NA-C stated she was aware of the need to reposition R20, but there was limited staff available to assist. At 10:03 a.m. NA-C and registered nurse (RN)-F brought R20 to the room for toileting. R20 refused to have her skin assessed by staff, stating her bottom was "wonderful".

On 8/15/18, at 10:10 a.m. RN-A stated R20 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 _____	C 08/16/2018

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 686	Continued From page 50 not been repositioned as there was not available staff and this placed the resident at increased risk for skin breakdown and developing pressure ulcers. On 8/16/18, at 12:15 p.m. licensed practical nurse (LPN)-A, Care Coordinator stated R20 was at moderate risk for skin breakdown and needed to be provided with timely assistance for turning and repositioning as determined by the assessment. On 8/16/18, at 3:32 p.m. the director of nursing stated the frequency of resident turning and repositioning was based on the TT assessment. Staff are to implement the time frames as determined by the assessment. A facility policy titled Skin Assessment and Wound Management dated July 2018 was received and indicated a pressure ulcer risk assessment (Braden Scale) would be completed for every resident upon admission and weekly times (X) three weeks. Additionally, Tissue Tolerance Observations (lying and sitting) and Tissue Tolerance Evaluation were to be completed on admission/re-admission, annually, upon significant change and with the development of a pressure related skin impairment. Staff were directed to perform routine skin inspections with daily cares and nurses were to be notified if skin changes were observed.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		9/25/18

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 _____	C 08/16/2018

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 689	Continued From page 51 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow smoking safety interventions as identified on their smoking evaluation and care plan for 1 of 2 residents (R2) investigated for smoking safety. The facility also failed to provide consistent ambulation assist and implement fall interventions for 1 of 3 residents (R242) identified as at risk for falls and subsequent injuries. SMOKING R2's quarterly Minimum Data Set (MDS) dated 7/26/18, identified R2 had severe cognitive impairment. R2's MDS further identified diagnoses which included: dementia, hypertension and heart disease. R2 was independent and required some supervision with activities of daily living (ADL). R2's care plan, revised 8/3/18, identified the following; R2 currently smoked at this facility, and was independent with smoking per evaluation. R2's significant other called the facility on 8/3/18, and notified the facility that due to financial concerns for resident, family was unable to supply unlimited cigarettes for resident. Family would supply cigarettes for R2 to smoke 2 cigarettes, four times each day. The facility reviewed with R2 and he was in agreement with the smoking plan. Smoking apron per evaluation. R2 was noted to have two cigarette burns in w/c (wheelchair) cushion. Staff reassessed R2 and found that R2 needed to have a smoking apron	F 689	R2 was reviewed and assessed for free of accident hazards/supervision and devices specific to smoking. R242 was reviewed and assessed for free of accident hazards/supervision and devices specific to falls. R2 and R242□s plan of care and interventions have been updated. All current residents who have been identified for smoking safety and risk of falls have had their interventions and plan of care reviewed and updated to reflect interventions for safety. All current residents who have been identified for risk of falls, have had their assessments, interventions and plan of care have reviewed and updated to reflect fall interventions. All resident who have been identified to be a smoker, their assessments, interventions and plan of care have been reviewed and updated to reflect smoking safety. Staff will be re-educated on smoking safety interventions and implementations of fall interventions. An audit of 3 current residents with smoking safety and fall interventions are in place, will be completed weekly x4, and then monthly x2.	

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 _____	C 08/16/2018

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 689	Continued From page 52 on at all times when smoking to decrease risk of burns to w/c cushion or self. Staff to cue or remind R2 to fasten apron around his neck and smoking materials will be kept at nurses station. R2's smoking Evaluation effective 8/3/18, identified R2 had cognitive loss and smoked 2 to 5 times per day. The need for adaptive equipment identified a smoking apron by a check mark. R2's smoking evaluation further identified family/significant other would supply for R2 to smoke 2 cigarettes, four times per day. R2's smoking materials would be kept behind the nurses station and R2 was to ask for cigarettes. R2's smoking evaluation further identified R2 was to wear a smoking apron at all times when smoking and was independent with smoking and able to light his own cigarettes and distinguish them safely. On 8/13/18, at 6:46 p.m. R2 was sitting in his wheelchair in his room. R2 indicated he had designated smoking times then pointed to an 8 X 11 inch paper on his bulletin board on the wall behind him. The paper identified smoking times as 9:30 a.m., 1:30 p.m., 3:30 p.m. and 7 p.m. R2 had a cigarette in his left hand, resting on his lap, covered by his shirt tail, which he showed to surveyor. R2 indicated he already went out, so would go out tomorrow at 9:30 a.m. to smoke. R2 then indicated he would go out at 7 p.m. to smoke. R2 indicated he had his own lighter, then pulled a black lighter out of his inside shirt pocket to show surveyor. No burn holes were noted in R2's clothing. At 6:54 p.m. R2 was observed wheeling self independently towards the courtyard door to the outside smoking area. R2 was stopped by activities director (AD)-A who gave R2 a smoking apron to apply, which he did. R2 then	F 689	Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 689	Continued From page 53	F 689		

proceeded outside, then smoked independently. Director of nursing (DON) was observed sitting at a table near R2 while he smoked working on a lap top computer. At 7:08 p.m. R2 gave his apron to registered nurse (RN)-D. RN-D then asked R2 for his cigarettes, which he gave to her. RN-D then indicated to surveyor R2 needed to turn in his cigarettes, because R2 could not remember how many he smoked. RN-D asked nursing assistant (NA)-I if he needed to turn in his lighter, and NA-I indicated he could keep it.

On 8/14/18, at 3:08 p.m. R2 wheeled self out of his room into the hallway. R2 showed surveyor he had his black lighter, and an empty pack of Marlboro cigarettes. R2 indicated he was waiting for 3:30 p.m. when he could go out to smoke.

On 8/15/18, at 9:29 a.m. R2 was at the nurses desk and was given 2 cigarettes. R2 wheeled self outside to smoking area independently. R2 did not have a smoking apron on.

On 8/15/18, at 1:27 p.m. NA-D indicated the facility had an open smoking policy for residents who smoked. NA-D indicated the residents who smoked could keep cigarettes on them, and were not supervised and were assessed to be able to do so. NA-D indicated those who could not smoke independently, did not smoke.

On 8/16/18, at 1:38 p.m. director of nursing (DON) indicated R2 was safe to smoke independently. DON indicated she completed the resident smoking assessments and would go out with residents while they smoked and watch them. DON indicated she had completed a smoking evaluation this week for R2. DON indicated R2 would ask for a smoking apron at

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 _____	C 08/16/2018

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 689	Continued From page 54	F 689		

times, but indicated he did not need one. DON indicated R2 could keep his cigarettes. She indicated R2 kept an empty box of cigarettes, and the nursing staff would provide him with 2 cigarettes when he went out to smoke. DON indicated at times he would have up to 6 cigarettes in his box. DON indicated R2 could also keep his lighter and had not lit up a cigarette in the building. DON indicated that R2 was more confused when he first arrived and that was when he had burns in his wheelchair cushion. DON indicated he was now safe to smoke, as she had assessed his skin and clothing for burns. DON confirmed the smoking evaluation dated 8/3/18, identified R2's smoking materials were to be kept behind the desk.

Nursing assistant care sheets, titled Group D, updated 8/14/18, at 2:24 p.m. identified R2 had scheduled smoking times of 9:30 a.m., 1:30 p.m., 3:30 p.m., and 7:00 p.m. Staff were instructed to ask and ensure that R2 gave back smoking materials except for lighter. The form further indicated R2 did not require a smoking apron at that time, if he requested to assist him to wear it correctly.

R2's smoking evaluation effective 8/13/18, at 6:56 p.m. identified R2 had cognitive loss. The evaluation identified R2 had previously worn a smoking apron, but has since been assessed to be safe without one. R2's clothing and wheelchair were assessed and no burn damage was found anywhere and no burns to his fingers. The evaluation further identified R2 kept his own lighter with him in his pocket and had made no attempts to smoke inside the facility, followed the rules outdoors and required no supervision or protective wear. R2 was to be assessed daily 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 _____	C 08/16/2018

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 689	Continued From page 55	F 689		

burns on clothing or skin from nursing staff.

The facility policy titled Resident Smoking Policy, dated 7/08, identified all residents who smoke would be evaluated for the need of adaptive equipment. The policy further identified all residents who choose to smoke will be evaluated upon admission, significant change in condition or cognition, or exhibited inability to follow safe smoking practices. Storage of supplies varied depending on resident's cognitive abilities and was individualized based on the resident's smoking assessment.

FALLS
R242's admission Minimum Data Set (MDS) dated 8/6/18, indicated R242 had moderate cognitive impairment with poor decision making skills and required cues and supervision related to wandering behaviors and used a wander/elopement alarm. The MDS indicated R242 received limited assistance with walking and used a walker and wheelchair.

The ADL (Activities of daily living) Care Area Assessment (CAA) worksheet, dated 8/10/18, identified R242 needed limited staff assistance and a walker for walking. Additionally, the CAA identified R242 was at a risk for personal safety related to a history of falls, vision impairments, and medical diagnoses of encephalopathy (brain dysfunction due to a medical disorder), and altered mental status.

R242's Initial/Comprehensive Careplan, effective date 7/31/18 indicated R242 had impaired mobility related to an unsteady gait and was at risk for falls/injury related to wandering behavior,

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 _____	C 08/16/2018

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 689	Continued From page 56	F 689		

memory loss, history of impulsivity, and a history of falls. R242 received physical therapy (PT) and staff were to assist with walking and transfers with the use of walker or wheelchair. R242 had a visual alteration/impairment and wore glasses.

The nursing assistant care sheet (directions for care of resident), undated, did not identify R242's glasses, walker, or wheelchair nor what assistance was required to assure safety.

On 8/13/18 at 1:57 p.m. R242 was observed walking in the hallway with the use of a rolling walker, wearing glasses with a yellow tag hanging from the right bow that read "Reading glasses". R242 had a wander guard on his left and red gripped slippers.

On 8/13/18, at 6:37 p.m. R242 was observed in his room wearing the yellow tagged reading glasses. R242 stated he was unaware what the tag meant, adding he had two pairs of glasses, one for reading and a larger pair for use outside. R242 stated he tried to wear the reading glasses at all times, even outside, but this made his vision blurrier. A pair of yellow protective glasses were observed on R242's bedside table, there was no tag on these.

On 8/14/18, at 10:30 a.m. R242 was observed walking without his walker, with a side to side, stiff legged gait, from the day room area to the nurses station. R242 was leaning on the counter, conversing with licensed practical nurse (LPN)-A, Care Coordinator. At 10:40 a.m. R20 remained interacting with staff as they passed by even though he did not have his walker. Multiple staff members passed by and greeted R242 while passing, including registered nurse (RN)-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 _____	C 08/16/2018

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 689	Continued From page 57	F 689		

LPN-B and Nurse Consultant Assistant (NCA). No one asked R242 about his walker, provided assistance or retrieved his walker even though R242 was identified at risk for falls.

On 8/16/18, at 8:34 a.m. R242 was standing near the medication cart for medication pass wearing his (reading) glasses with the yellow tag on the bow. R242 commented he could not see with his glasses. LPN-B informed R242 the tag on right bow stated "Reading only". LPN-B stated "They are probably not good for walking." R242 went to leave the area without his walker and was prompted by LPN-B to remember his walker, however, did not provide R242 with prompts or assistance to change his glasses.

On 8/16/18, at 9:09 a.m. R242 was observed in the day room area self-propelling his wheelchair. R242 was wearing a different pair of glasses with side protectors. He stated, these were his "old glasses" and they worked better, adding "I can see now."

On 8/16/18, at 10:09 a.m. the director of physical therapy (DPT) stated R242 was receiving therapy and they recommend consistent use of a walker with supervision. If the resident had no walker, staff should give prompts to use the walker and assist to walk and/or retrieve his walker.

On 8/16/18, at 10:15 a.m. nursing assistant (NA)-C stated she was aware R242 needed his walker when walking and would provide prompts and assistance for him to use it.

On 8/16/18, at 2:27 p.m. LPN-A stated R242 uses his walker at all times. They placed a sign on his walker as a visual cue to remind him to use it. If

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 _____	C 08/16/2018

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 689	Continued From page 58 he does not have the walker, staff should walk with him hand in hand and obtain his walker. On 8/16/18, at 3:09 p.m. the director of nursing (DON) stated R242 was to use his walker at all times as directed by PT and this should be reflected in the plan of care and staff should monitor for this and assist as needed. Although R20 was identified by the facility at risk for falls, the facility was not consistently implementing fall interventions to use "regular glasses's" and not reading glasses when walking. Nor, were they providing consistent cues and assistance to use a walker at all times to reduce his risk for falls. A facility policy titled Falls Prevention and Management Protocol revised 7/2018, indicated a fall risk assessment was completed for residents which identified risk factors for falls. Interventions were identified to try to prevent resident falls and to minimize complications from falling. The policy indicated if underlying risk factors were not corrected, staff were to try various interventions until the falling had stopped or was identified as unavoidable.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		9/25/18

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 _____	C 08/16/2018

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 725	Continued From page 59 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet activities of daily (ADL's) living for 3 of 5 residents (R6, R23, R1) whom were dependent upon staff for ADL's, 4 of 4 residents (R6, R1, R4, R20) reviewed for pressure ulcers, 1 of 1 residents (R27) reviewed for privacy , and 3 residents (R292, R4, R23) and 1 of 3 family members (FM-A), and 8 staff members (NA-B, NA-L, NA-K, NA-J, NA-M, NA-D, RN-C, LPN-A) whom voiced concerns with the lack of sufficient nursing staff in the facility. This had the potential to affect all 38 residents in the facility. Findings include: ADL's NOT MET:	F 725	R6, R23, and R1 have been assessed to ensure their activities of daily living are being met based on the facilities adequate nursing staff. R6, R1, R4, and R20 have been reviewed and assessed for pressure ulcers based on facilities adequate nursing staff. R27 has been reviewed and assessed for privacy based on facilities adequate nursing staff. R292, R4, and R23 have been interviewed regarding voiced concerns with the lack of adequate nursing staff. The facility has adjusted staffing to ensure residents needs are being met through recruitment and retention. All residents have the potential to be affected if the facility does not have	

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 _____	C 08/16/2018

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 725	Continued From page 60 R6's admission Minimum Data Set (MDS) dated 5/29/18, identified R6 had severe cognitive impairment and required extensive assistance with toileting. R6 was always incontinent of bladder and bowel. R6 was continuously observed on 8/14/18, from 8:22 a.m. to 10:56 a.m. (2 hours and 34 minutes)while in bed. R6 was not checked for bladder or bowel incontinence. A moisture-absorbing pad (about 2 feet by 2 feet in size) was under R6's bottom. R6's incontinent brief was visibly wet and soiled, and the smell of urine was prevalent in the room. The pad under R6 was also visibly soiled and wet, and smelled of urine, and the wetness had moved beyond the edges of the pad, and onto the surrounding bed sheet was also wet. At 9:26 a.m. nursing assistant (NA)-A walked into R6's room and peered at R6, noted he was asleep, then left the room. R23's admission MDS dated 5/22/18, identified R23 had severe cognitive impairment and required extensive assistance with personal hygiene. R23 was observed on 8/14/18, at 9:12 a.m. nursing assistant (NA)-B wheeled R23 from his room to the dining room for breakfast. R23's hair was not brushed. It was flat in the back and sticking up on the top of his head. At 3:39 p.m. R23 stated NA-B got him ready that morning and did not brush or offer to brush his hair before going to the dining room. R23 did not ask NA-B to brush his hair because she so busy and rushed. "She was so "frazzled" he didn't want to mention it to her. R1's quarterly MDS dated 4/20/18, identified R1 had severe cognitive impairment and required extensive assistance with toileting. R1 was always incontinent of bladder. R1 was observed	F 725	adequate nursing staff. The facility will review staffing, census and acuity daily to ensure resident needs are being met. The facility will not be accepting admits if staffing levels do not meet resident needs. All staff have been educated on the mandatory staffing requirements to assure that the facility is staffed appropriately daily. Staff will be re-educated on appropriate staffing levels based on census and acuity within the facility. An audit of 3 current residents to ensure all cares are being completed, specific to ADL□s, pressure ulcers, and privacy will be completed weekly x4, and then monthly x2. Three resident/family interviews specific to adequate nursing staffing will be completed weekly x4, and then monthly x2. Three employee interviews specific to adequate nursing staffing will be completed weekly x 4, and then monthly x2. The facility will complete weekly staffing meetings specific to adequate nursing staff. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion	

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 _____	C 08/16/2018

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 725	Continued From page 61 on 8/15/18, beginning at 5:36 a.m. until 8:49 a.m. (3 hours and 13 minutes) R1 remained lying in her bed, smelling of urine, until staff assisted with morning cares at 8:49 a.m..When NA-E removed R1's incontinent product, NA-E described the brief as having "moderate" amount of urine, and when she tossed it in the trash, one could hear it thump when brief hit the bottom. R1's brief appeared heavily saturated. At 10:09 a.m. NA-E stated she probably "behind schedule." in regards to assisting R1 with incontinence cares. PRESSURE ULCERS: R6's admission MDS dated 5/29/18, identified R6 had severe cognitive and required extensive assistance with activities of daily living. The pressure ulcer Care Area Assessment dated 5/29/18, identified R6 had a stage 3 pressure ulcer to his coccyx, and identified R6 should be repositioned every 2 hours. R6 was continuously observed on 8/14/18, from 8:22 a.m. to 10:56 a.m. (2 hours and 34 minutes) R6 was not offered repositioning. R6 was in bed lying on his right side. A moisture-absorbing pad (about 2 feet by 2 feet in size) was under R6's bottom. R6's incontinent brief was visibly wet and soiled, and the smell of urine was prevalent in the room. The pad under R6 was also visibly soiled and wet, and smelled of urine, and the wetness had moved beyond the edges of the pad, and onto the surrounding bed sheet was also wet. At 9:26 a.m. NA-A walked into R6's room and peered at R6, noted he was asleep, then left the room. During a subsequent, continuous observation on 8/15/18, from 5:35 a.m. to 8:06 a.m., (2 hours and 31 minutes), and R6 was observed seated in a Broda-style wheel chair (a larger chair which can be reclined), without being assisted or offered	F 725	and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 725	Continued From page 62	F 725		

to reposition.

R1's quarterly MDS dated 4/20/18, identified R1 had severe cognitive impairment. The pressure ulcer CAA dated 8/8/18, indicated R1 was at risk for pressure ulcers. The CAA for pressure ulcers identified R1 as at risk for the development of pressure ulcers due to requiring extensive assist with bed mobility, sits and lies for extended periods of times, which was further complicated by R1's refusal of cares from staff when incontinent and was on a turn and reposition schedule every 2 hours. R1 was observed on 8/15/18, beginning at 5:36 a.m., R1 was observed lying in her bed on her left side. The smell of urine was prevalent near R1 and a pervasive, heavy, moist scent of urine was present throughout R1's room. At 8:31 a.m. R1 woke and yelled out "somebody come in here please... will somebody come in here when they have the time, please?" and then repeats the requests three more times. R1's call light is not activated, and there are no staff present in the hallway. At 8:49 a.m., (3 hours and 13 minutes since the start of observation, NA-E entered R1's room, began to interact and started morning cares. R4's quarterly MDS dated 5/1/18, identified R4 was cognitively intact and required extensive assistance with bed mobility. R4 had a Stage 2 pressure ulcer that was present upon readmission to the facility and received pressure ulcer care. MHM Weekly Pressure Wound Evaluation dated 8/14/18, identified an intervention to reposition every 1-2 hours. R4 was observed continuously on 8/15/18, at 5:33 a.m. until 8:24 a.m. (2 hours and 51 minutes) R4 was sleeping on her right side on a full air mattress in her room and was not repositioned or offered to be repositioned.

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 _____	C 08/16/2018

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 725	Continued From page 63	F 725		

R20's admission MDS date 6/26/18 indicated R20 had moderate cognitive impairment and required extensive staff assistance with activities of daily living (ADL's), incontinent of bowel and bladder, was at risk for pressure ulcer development and had no skin issues. On 8/15/18, at 7:13 a.m. R20 was observed during personal cares provided by nursing assistant (NA)-C. R20 had a area approximately 2 cm in diameter under her right gluteal fold which was pink, with no open areas. During continuous observation on 8/15/18 from 7:20 a.m. to 10:03 a.m., R20 remained seated in her wheelchair, without any assistance with toileting or repositioning, a total of 2 hours and 43 minutes. At 9:52 a.m. the surveyor notified staff of R20 not being repositioned timely. NA-C stated she was aware of the need to reposition R20, but there was limited staff available to assist. At 10:03 a.m. NA-C and registered nurse (RN)-F brought R20 to the room for toileting and repositioning. R20 refused to have her skin assessed by staff.

PRIVACY:
R37's significant change MDS dated 7/18/18, identified R37 had severe cognitive impairments and needed extensive assistance with bed mobility and dressing. R37 was observed on 8/16/18, at 8:18 a.m. lying on his back in his bed, with his blue and white hospital gown bunched up at the waist, exposing his lower abdomen, genital area, legs and stockinged feet. R37 had an incontinent pad lying under his buttocks and pulled down between his knees. R37's blanket and sheet were lying next to his right side. R37's door was wide open to the hallway. His curtain was pulled open bunched up covering an area

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 _____	C 08/16/2018

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 725	Continued From page 64	F 725		

next to the wall and at the foot of his bed approximately 2 feet. R37's supra pubic catheter leg bag was lying next to his outer left thigh. No staff were present in R37's room. At 8:19 a.m. NA-A entered R37's room, stood next to R37's bed and began talking on his walkie talkie to nursing assistant (NA)-B. He asked NA-B what she had been doing with R37. NA-A stated NA-B told him R37 had been in the middle of a bowel movement and required two staff to reposition him. NA-A then repositioned R37's incontinent pad over his genital area, then pulled his gown down to cover his abdomen, genital area and thighs, then covered R37 with his sheet and blanket.

RESIDENT COMPLAINTS REGARDING STAFFING CONCERNS:
On 7/8/18, the state agency received a complaint regarding R292 not receiving personal hygiene cares timely and concerns related to staffing. The complaint identified R292 required staff assistance and transferred to the hospital on 7/8/18.

R4's quarterly MDS dated 5/1/18, identified R4 was cognitively intact and required extensive assistance with bed mobility On 8/13/18, at 7:12 p.m. R4 stated she had a pressure ulcer on her bottom and had been seated in her wheelchair since she returned from the hospital that day in the early afternoon. Further, staff had not offered to reposition her. R4 stated she was supposed to be repositioned every two hours when she was sleeping but the staff did not always reposition her.

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 _____	C 08/16/2018

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 725	Continued From page 65	F 725		

R23's admission MDS dated 5/22/18, identified R23 had severe cognitive impairment and required extensive assistance with activities of daily living. On 8/14/18, at 8:21 a.m. R23 stated it frequently took one half hour to an hour to answer his call light. R23 also stated the nursing staff frequently delivered his breakfast tray late. Breakfast was supposed to be at 8:00 a.m. and he frequently did not receive it until 9:00 a.m.

FAMILY COMPLAINTS REGARDING STAFFING:
During interview on 8/13/18, at 6:30 p.m. family member (FM)-A stated the facility sometimes staffed the facility with half the amount of staff needed. FM-A frequently complained his wife was "wet or soiled." The care gets better after he complains, but then it goes back to the same way. There had been a lot of staff turnover and stated he had never seen most of the staff who were working that evening.

STAFF CONCERNS REGARDING STAFFING:
During interview on 8/14/18, at 9:15 a.m. nursing assistant (NA)-B stated it was hard to get cares and tasks completed when they were the only regular aid on the floor while trying to train in temporary nursing pool staff. NA-B stated in the last couple of weeks she and another aid had each worked about 160 hours in a 2 week pay period. Residents had complained that although there were enough bodies with the pool staff note, the pool staff were slow and not familiar with the residents care. Further, there were 2 residents still in bed because the staff were so behind on assisting resident with morning cares.

During interview on 8/14/18, at 10:55 a.m. NA-L

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 _____	C 08/16/2018

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 725	Continued From page 66	F 725		

stated staff had struggled recently with getting shift filled to care for the residents. Two weeks ago it got a lot worse when summer staff went back to school and it had been a struggle ever sense to complete resident care timely.

On 8/14/18, at 3:15 p.m. NA-K stated staffing could "improve" and some residents were incontinent because the staff were not able to toilet them timely. Sometimes baths were not completed and were passed on to the next shift.

During interview on 8/15/18, at 5:36 a.m. NA-J stated staffing had been a struggle recently for the day and evening shift. There had been a lot of staffing changes and the facility recently had to obtain pool staff to cover shifts.

On 8/15/18, at 1:08 p.m. NA-M stated she worked for the nursing pool and it was only her second day at the facility. She was not familiar with the residents cares.

On 8/15/18, at 1:15 p.m. NA-D stated at times the staff were having difficulty answering call lights timely and toileting residents on time. The nursing pool needed to be brought in because the staff were getting burned out and forgetting things and residents getting upset.

During interview on 8/16/18, at 9:46 a.m. RN-C stated she had noticed recently resident's shaving, general grooming and baths were not being completed as care planned. Further, the facility was in the process of hiring staff and had temporally hired a nursing pool to alleviate the staffing concerns.

When interviewed on 8/16/18, at 9:46 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 _____	C 08/16/2018

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 725	Continued From page 67	F 725		

licensed practical nurse (LPN)-A stated the facility acquired nursing pool staff on 8/10/18, because the facility was struggling with staff meeting the resident needs. She stated it had been difficult, but thought the facility was "managing." Further, the nursing staff have been on the floor trying to help the staff with completing resident cares.

On 8/16/18, at 11:02 a.m. registered nurse (RN)-A stated there was not enough nursing staff to completed the cares timely. It takes time to get to know resident routines and the nursing pool staff do not know resident routines and things are taking longer to get done

During interview on 8/16/18, at 1:49 p.m. the staffing coordinator (SC) stated the facility staffed the building based on census and level of care needs. Staffing was reviewed daily Monday through Friday and adjusted as needed. The facility was in the process of completing the hiring process for several nursing positions and recently had to hire nursing pool staff to cover the staffing gap. The pool staff started in the facility on 8/10/18. SC stated with the pool staff they facility physically had enough bodies to provide care; however, the pool staff were not familiar with the facility and residents and behind on meeting resident needs.

When interviewed on 8/16/18, at 2:08 p.m. the director of nursing (DON) stated staffing the facility had been difficult the last 6- 8 weeks. The facility was in the process of hiring staff to replace the summer staff returning to school, when there were several unexpected staff leaves, that left the facility staff working a lot of hour trying to cover shifts. The facility was actively hiring staff and expected to stop using the nursing pool staff 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 _____	C 08/16/2018

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 725	Continued From page 68 9/15/18, after orientating the newly hired staff. Hiring the nursing pool was an emergency fix and understood resident cares were behind. The facility assessment dated 11/21/17, identified the census was reviewed daily to determine staffing levels. The facility identified an average daily census of 40 residents. The facility identified the various staff types needed; however did not identify how nursing staff on average, were needed to ensure adequate staffing.	F 725		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance to ensure personal clothing was available for 1 of 1 residents (R242) who lacked ability and support to coordinate services independently following admission to the facility. Findings include: R242's admission Minimum Data Set (MDS) dated 8/6/18, identified R242 had moderate cognitive impairment with poor decision making, required cues, supervision and oversight with dressing and grooming. R242's Initial/Comprehensive Careplan dated 7/31/18 identified R242 had an activities of daily living (ADL) self-care deficit and included a goal	F 745	R242 has been provided personal clothing. All current residents have been assessed to ensure they have appropriate personal clothing items. Staff will be re-educated on ensuring residents have appropriate personal clothing items in a timely manner. An audit of 3 residents to ensure appropriate personal clothing items are received in a timely manner following admission to the facility will be completed weekly x4, and then monthly x2. Social Services Director or Designee will	9/25/18

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 _____	C 08/16/2018

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 745	Continued From page 69 for R242 to be neat and well-groomed daily during the review period. R242 was observed on 8/13/18, at 6:54 p.m. in the day room wearing a dark green long sleeved shirt with gold embroidery on it, denim jeans, and red gripper socks. On 8/14/18, at 10:24 a.m. R242 was wearing the same dark green shirt, denim jeans and gripper socks. R242 responded he was unsure what the letters on the shirt stood for as "They gave it to me.". R242 stated he had some clothes here, and opened his closet door which contained a pair of khaki slacks. R242 had a blue and white polo shirt laid out over the nightstand. On 8/15/18, at 8:51 a.m. R242 was in the dining room wearing the same dark green shirt, sweat pants and gripper socks. On 8/16/18, at 9:50 a.m. he was in the dining room, again wearing the same dark green shirt, denim jeans and gripper socks. R242 stated he got his shirt up north and stated his "Ma and sister" helped pack for him. Although R242 was wearing the same green shirt and red slippers R242 was clean in appearance and free from personal odors. On 8/16/18, at 10:09 a.m. the director of physical therapy (DPT) stated he worked with R242 on mobility training and has seen R242 in a hospital gown on occasion. He was unsure if R242 had other clothing, than the green shirt, jeans and socks. During interview on 8/16/18, at 10:15 a.m. nursing assistant (NA)-C stated R242 was independent with dressing and grooming and came to the facility with jeans and T-shirt. They had gotten him a white and blue striped polo shirt and sweat pants from donated items at the facility. NA-C stated she was unaware R242 had	F 745	be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 745	Continued From page 70 been wearing the same clothes for the past four days. On 8/16/18, at 10:20 a.m. social services (SS)-A stated R242 had received a box of personal goods today which had been sent by R242's family member (FM)-E, sixteen days after R242's admission to the facility. She was unaware R242 only had one outfit to wear since his admission but was aware laundry borrowed him a shirt and pair of pants. SS-A stated she spoke with FM-E regarding R242's needs on 8/14/18, two days ago. They should have communicated with FM-B when they were aware R242 had no clothing. During interview on 8/16/18, at 2:27 p.m. licensed practical nurse (LPN)-A who was the Case Manager stated SS-A contacted FM-E about his clothing. Staff should be aware of any resident's needs upon admission, and assist them to get the items needed. On 8/16/18, at 3:09 p.m. the director of nursing (DON) stated staff should be aware of residents needs upon admission and coordinate services as needed. A policy to ensure residents have clothing available for use was requested and not provided.	F 745		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		9/25/18

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 _____	C 08/16/2018

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 791	Continued From page 71 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine dental	F 791	R23 was offered routine and emergency dental services and has accepted	

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 _____	C 08/16/2018

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 791	Continued From page 72 services were provided for 1 of 1 residents (R23) observed to have a loose lower denture. Findings include: R23's admission Minimum Data Set (MDS) dated 5/22/18, identified R23 had severe cognitive impairment and section L0200 did not identify any dental problems. R23's MHM Admit/Initial Data Collection V-2 dated 5/16/18, identified R23 had a loose or ill fitting denture. Further, R23 had a upper and lower denture. The section related to dentist name and last visit was blank. The section requiring a dental summary was blank. R23's MHM Initial Comprehensive Careplan dated 5/16/18, identified R23 had dentures but did not address the lower denture was ill fitting or the need for a dental referral. The care plan directed staff to arrange for dental follow up as needed. On 8/14/18, at 3:39 p.m. R23 stated he had a loose lower denture since admission to the facility. R23 stated he would like to see a dentist about the loose denture. Further, the facility had never offered to arrange dental services for him. When R23 was talking his lower denture moved within his mouth. During interview on 8/15/18, at 1:06 p.m. registered nurse (RN)-A stated the admitting nurse usually completed the initial resident assessment. RN-A was not aware if R23 was seen by a dentist for his loose dentures. Further, RN-A stated he had observed R23's dentures sliding in and out of his mouth and clicking while	F 791	services. Routine/Emergency Dental services plan of care and interventions have been updated to reflect dental services. All current residents who have been identified for the need of dental services have been offered services. Residents plan of care have been reviewed and updated. Staff will be re-educated on all appropriate current dental services that are offered through the facility. An audit of 3 current residents for proper fitting of dentures and to ensure proper dental care will be completed weekly x4, and then monthly x2. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 791	Continued From page 73 he was eating. He did not offer R23 a referral to a dentist. During interview on 8/16/18, at 9:46 a.m. RN-C stated the nurse completing the oral assessment sections should have completed the assessment and made a referral to dentist to address his loose bottom denture. Further, because the admission MDS was not accurate, it did not trigger a dental care area assessment for a comprehensive assessment of R23's dental needs. R23's medical record did not identify R23 was seen by a dentist. A policy on routine dental services was requested and not received.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		9/25/18

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 _____	C 08/16/2018

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 812	Continued From page 74 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently track and monitor dishwasher rinse temperatures and take timely action when rinse cycle temperatures fell below recommended levels for 1 of 1 dishwashers observed. This had the potential to affect all 38 current residents who ate food served from dish and tableware that were cleaned in the dishwasher. Findings include: On 8/13/18, at 1:17 p.m. during an initial brief tour of the facility kitchen, staff were observed washing dishes using a Hobart brand, high temperature washer. The thermometer on the wash cycle was registered 161 deg F (degrees Fahrenheit), and the rinse cycle temperature was 171 deg F. When the surveyor asked the staff who was washing dishes about the temperature readings, culinary services aide (CSA)-A said something in Spanish, and shook her head, then smiled. At 1:53 p.m. a number of cycles were observed, but the rinse temperature never exceeded 171 deg F. Culinary Services assistant director (CSAD) came to the wash area and also noted the rinse temperature of 171 deg F. CSAD then ran a couple of cycles, and in the presence of surveyor observed rinse cycle temperatures ranging between 171 to 175 deg F. At 2:01 p.m. the CSAD placed an analog food thermometer on a dish rack, and ran two cycles. Each time the thermometer registered less than 175 deg F. Located near the dishwasher in a plastic sleeve	F 812	The facility is consistently tracking and monitoring dishwasher rinse temperatures at a minimum of 3 times a day, and have repaired the dishwasher machine to ensure proper operation per manufacturers guidelines. All residents have the potential to be affected if the facility fails to consistently track and monitor the dishwasher rinse temperatures and ensure appropriate operational function of the dishwasher. Staff will be re-educated on consistently tracking and monitoring dishwasher rinse temperatures per culinary department procedure of a minimum of 3 times per day. Staff will be re-educated on using TELS for maintenance work orders for items needing repairs or maintenance. Staff will be re-educated on immediately notifying their supervisor of equipment needing service, so repairs can be completed timely. Staff will be re-educated on the culinary department procedure for manual dishwashing in the event the dishwasher machine is not properly operating per manufactures guidelines. Audits of the facilities dishwasher temperatures will be completed weekly	

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 _____	C 08/16/2018

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 812	Continued From page 75 was a form, untitled, but dated August 2018, and the form was used to record dishwasher wash and rinse cycle temperatures. The form instructed to: "Please log WASH and RINSE temperatures when washing dishes after each meal to ensure that the wash and rinse temperature are properly monitored and controlled. The log should be filled in and signed by those who are directly involved in the dishwashing process." The form did not specify a number or range of what wash or rinse temperatures were expected. The form had a row for each day of the month, and columns, which identified the date and places to document wash and rinse temperature for breakfast, lunch and dinner (3 each for wash and rinse, a total of 6 daily entries) and space to document one's initials. From August 1st, through August 12th, breakfast wash and rinse temps were documented on three days (8/2, 8/11 and 8/12); lunch wash and rinse temperatures were documented on two days (8/11 and 8/12); and dinner wash and rinse temperatures were documented on seven days (8/1, 8/3, 8/6, 8/7, 8/8, 8/11 and 8/12). There were no other dates/times documented. On four days (8/4, 8/5, /9 and 8/10) there was no documentation of any wash and rinse temperatures for any meal. A review of July (no year documented) Dishwashing wash and rinse temperatures indicated all temperatures, for all three meals for each day in July were documented. For the month of July, there were a total of 93 rinse temperature entries, and the documented rinse temperature at the breakfast meal on 7/9/18 was 180 deg F. All of the remaining 92 documented rinse temperatures for July were less than 180 deg F, and fell in range from 170 to 175 deg F.	F 812	x4, and then monthly x2. Administrator or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 812	Continued From page 76	F 812		

When interviewed on 8/13/18, at 1:43 p.m., the CSAD stated after reviewing the dishwasher temperature logs for August, he stated the rinse cycle temps (temperature) have been running between 171 to 172 degrees for "at least the last few days." The CSAD stated the wash temperature needed to be at least 160 degrees, and the rinse temps (temperature) had to be at least 180 degrees. The CSAD stated he should have been monitoring the wash temps (temperatures) and did not know why the temperatures were missing for most of the month of August. The CSAD stated however, there was recently someone in who made repairs to the dishwasher, stating it was recent, but not able to exactly say when this happened.

When interviewed on 8/13/18 at 2:16 p.m. the facility administrator stated he was "unaware of any problem" with the dishwasher and that, he would immediately check with ECO lab (a vendor). The administrator stated he did not know how the wash temps (temperatures) were monitored, and stated there certainly are gaps in the temperature log for August, ""I'll grant you that." During a subsequent interview on at 6:01 p.m. the administrator stated the dishwasher vendor was just here and made some adjustments to the machine. A wash cycle was run in presence of surveyor during interview, which indicated wash temperature at 164 deg F, and the rinse cycle was 190 deg F. A number of cycles were run, with rinse cycle temperatures all exceeding 180 deg F. The administrator stated as a precaution, the evening meal would be served using disposable plates and dinnerware, and the dishes would be rewashed. The Administrator also reported there had been service by the vendor last week and repairs 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 _____	C 08/16/2018

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 812	Continued From page 77 been made and stated the gap in the temperature log monitoring was concerning because that meant there was a problem," and it was not reported." Facility infection control logs were reviewed from June 2018 to present and there was no indication gastro-intestinal outbreaks or food-borne illness related infections. During the time of the survey beginning August 13, 2018, there were no residents on isolation precautions. A review of a ECOLAB service call receipt indicated the dishwasher vendor was at the facility on 8/2/18 and again on 8/10/18, regarding diagnosing and repair of the dishwasher. During interview on 8/14/18, at 3:07 p.m. the dishwasher service vendor (DSV) stated yesterday he was called out to facility and adjusted the thermostat control. The DSV stated the heater was calling for too much heat, causing the circuit breaker to turn off, and thus it was not heating high enough. The DSV stated he adjusted the high limit thermostat, and now the dishwasher was functioning properly. The DSV stated wash temps (temperatures) should be 160 deg F and the rinse temperatures should reach and be 180 deg F. The DSV stated it was important for the facility to monitor wash and rinse temperatures, and to make sure dishware was clean and appropriately sanitized. A policy regarding the monitoring of dishwasher temperatures was requested, but not provided.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		9/25/18

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 _____	C 08/16/2018

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 880	Continued From page 78 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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 _____	C 08/16/2018

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 880	Continued From page 79 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 38 residents who resided in the facility.	F 880	Re-education was done with RN "F" immediately after the surveyor observed the incident and RN" F" expressed understanding and willingness to comply with properly cleaning the glucometer. Each resident has their own glucometer currently. Glucometers are cleaned per facility protocol and are kept in container/bag free from exposure to potential contamination. All Licensed Staff have been reeducated	

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 _____	C 08/16/2018

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 880	Continued From page 80 Additionally, based on observation, interview and document review the facility failed to ensure proper cleaning and disinfection techniques were used on a community blood glucose monitor observed in use with 1 of 1 residents (R29) observed for glucometer use. This had the potential to affect all 38 residents who could require use of the community glucometer to check their blood sugar. Findings include; Review of the facility's infection control surveillance program was conducted on 8/16/18, at 8:43 a.m. with director of nursing (DON). An infection surveillance log was provided for June and July 2018, combined, which was partially completed. No other logs were provided for July 2017, to May 2018. The facility provided a log titled Monthly Resident Infection Statistics-Month June-July 2018, dated 11/17, which included the following columns; -Y/N, facility or community acquired, lab, imaging or culture date results, type of organism, antibiotic resistance organism Y/N, Drug/Dose/Frequency, Start/End date total days of treatment, Outcome and adverse effects if applicable. The June-July 2018, log identified 10 residents. Many areas of the form were not complete. The data included on the form were as listed below; - type of infection/infection site listed was identified for 4 residents which included UTI (urinary tract infection)/COPD (chronic obstructive pulmonary disease) exac (exacerbation/worsening) possible pna (pneumonia), scrotal abscess, UTI and UTI/pneumonia aspiration.	F 880	on proper cleaning of a glucometer per Estates at Delano procedures. The results of the monitoring for proper cleaning of the glucometer(s) will be reviewed in the QA committee. The DON or designee will monitor of properly cleaning the glucometer with audits weekly x4 and then monthly x2. Audit results will be reviewed by QAPI Committee for further recommendations. An infection prevention and control program is in place and DON and nursing staff have been and will continue to be educated on prevention and control of any infections, infections will be tracked and precautions will be put in place, isolation if needed, in the least restrictive manner for resident. Hand hygiene and cleaning of shared and individual equipment has been implemented with continual education and updated information to all staff as indicated. Resident infections are tracked according to the following statistics: Type of Infection and site Onset of symptoms and date of onset McGeer Criteria met y/n Facility or Community acquired Labs, Imaging or Cultures Type of Organism (s) and if are MDRO and if is MDRO what is resistant to Antibiotic/Drug dose, frequency, start and stop dates with total days of treatment Outcome and any adverse effects if noted. Best Practice for our facility will include but is not limited to the following: In services for all staff on their roles in the data collection.	

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 _____	C 08/16/2018

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 880	Continued From page 81 -symptoms were identified for only 1 resident. The other 9 residents symptoms were not identified. -lab, imaging or culture date results; 6 included dates and 1 identified negative results and 1 as e-coli. -type of organism was identified for 4 residents. -antibiotic was included for 1 resident, which also identified "no" for antibiotic resistant organism, but failed to identify organism, dosage and frequency. -outcome was identified for only 1 resident, the other 9 residents' outcomes were not identified. -adverse effects were identified as none for 8 residents, the other 2 residents were not identified. -facility or community acquired was identified as facility for 2 residents, the other 8 residents were not identified as facility or community acquired. Areas of the form not completed for all residents included; onset date, McGeer Criteria Met, start/end date, and total days of treatment. The facility provided three maps of the facility which included; -UTI tracking, undated, with 4 rooms circled, 7 residents listed and hand written documention on the map including spot pericare and handwashing audits, review catheter care w/staff and antibiotic stewardship with nursing and families. -influenza, dates on form included 3/26, 3/27, 3/28, and 3/29. The map had written documentation on the map which included 2 resident names, full house Tamiflu, most staff treated/proph (prophylactic) MDH updated, and communication cleaning, precautions and	F 880	Instruction(s) on how to fill out the McGeer's and to keep them for analysis and reference Review of documentation will be conducted by DON or Designee to assure the above are being completed in real time and any education needed for nursing staff will then be completed. Clinical review of anyone with a known infection will be completed daily in AM huddle to discuss labs, antibiotics and types of infections. Antibiotic Stewardship program is in place and will be re visited on annual education, upon hire, care conferences for residents, admissions, and as indicated to assure all staff, residents and family are aware of our program. DON and Designee will analyze the data on the McGeer's as well as the facility infection statistic and monthly summary forms in real time using this information for reporting, and educational opportunities as indicated. Interventions and precautions will be placed immediately upon suspicion of or confirmed infection to protect the residents in the facility and staff, and visitors. In reference to an Outbreak example: Norovirus, Influenza: The facility would post for visitors to be notified, refrain from visiting, reeducation/continued education would be provided to visitors and staff on hand hygiene, use of PPE and vaccinations for influenza, assure that facility is well stocked with ppe, hand sanitizer and that environmental services are updated 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 _____	C 08/16/2018

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 880	Continued From page 82 education. -untitled map identified 12 rooms and resident initials with symptoms listed for emesis, loose stools and fever. Multiple interventions listed on map including isolation, hydration, education and supplies. Hand written note indicated 3/12-cleared up. On 8/16/18 at 8:44 a.m. DON confirmed she was responsible for the infection control surveillance program DON and confirmed she was the only person who completed surveillance of infections. She indicated manager on duty or on-call would follow up with illnesses. DON indicated she had done some mapping of illnesses, and provided three maps. DON confirmed she had not completed all areas of the tracking form for June and July 2018, and the facility had no further logs for July 2017, through May 2018. A facility policy for infection prevention and control program was requested and not provided. R29's 5 day PPS (Prospective Payment System) Minimum Data Set (MDS) assessment dated 6/26/18, indicated R29 had the diagnosis of diabetes mellitus (a group of diseases that affect how your body uses blood sugar (glucose). R29's Order Summary Report which was signed by the care provider on 6/12/18, indentified R29 should have blood glucose monitoring two times a day. On 8/14/18, at 3:45 p.m. registered nurse (RN)-F was observed as she performed blood glucose monitoring for R29. RN-F sanitized her hands with hand sanitizer, obtained supplies from cart,	F 880	that all emesis/body fluids are immediate cleaned up with approved Norovirus/ Influenza solutions and that all staff know what products are to be used for this. Admissions will be held, and room transfers if warranted will be implemented. Any reportable illness will be reported to the MDH by the DON. All staff are updated in real time by the DON or Designee of any infection or suspected infection, infections are also tracked on our census sheets to coordinate the rooming of residents. Hand Hygiene and protective personal equipment audits will be implemented and all daily as indicated Employee illnesses are tracked as well: Symptoms, Onset, Type, confirmation and treatment, follow up if needed and department(s) affected, these are tracked in real time and analyzed with results reviewed in QAPI , actions and outcomes and conclusions. F880 Surveillance - DON or Designee will observe, monitor and reeducate as needed to assure that proper cleaning of the glucometers is being adhered to, and use this data to analyze if changes in the education are needed to assure all nsg staff are doing correctly and residents are free from infection. Nursing staff are trained and will continue to be educated on the appropriate documentation of the resident with an infection, and antibiotic usage, to tell the story of how the resident is doing on the treatment and what the plan is during treatment as well as any changed during treatment and the outcome. Nurses will	

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 _____	C 08/16/2018

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 880	Continued From page 83 which included the facility glucometer (machine to monitor blood sugars) and proceeded to R29's room. RN-F then applied gloves, cleansed R29's finger with an alcohol wipe, wiped off R29's finger with a dry gauze, then pricked resident finger with a lancet to obtain a blood sample. The sample was obtained on the test strip which had been placed in the glucometer. RN-F returned to the med cart with the facility glucometer and supplies. RN-F placed the glucometer directly on the cart and wiped off the glucometer with Hand Sanitizing Wipes which contained 70% alcohol and placed the glucometer directly back into the storage container.RN-F stated this was her first day working at the facility as a pool nurse and she was not aware of what was normally used for glucometer cleaning. On 8/14/18, at 3:57 p.m. licensed practical nurse (LPN)-A care coordinator stated each resident had their own glucometer, however, a facility glucometer was available for use if needed. The facility glucometer was to be cleansed with bleach sani cloths both before and after use of the machine. Before returning the glucometer to the drawer, it was to be wrapped in the sani cloth and remain wet for one minutes and air dried for two minutes. LPN-A stated if the glucometer was cleaned with a hand sanitizing wipe it would not have been disinfected properly against blood borne pathogens (infectious microorganisms in human blood that can cause disease in humans.). On 8/14/18, at 4:01 p.m. the director of nursing (DON) stated all residents had their own glucometer if routine blood glucose monitoring was performed. If a facility glucometer was used for a resident, it should be disinfected with the	F 880	continue to be educated on what to report to the MD and how to continue to improve their dialogue with the MD and team The results of the monitoring for proper cleaning of the infection(s) will be reviewed in the QA committee. Audit results will be reviewed by QAPI Committee for further recommendations, at which time we will also discuss trends, education provided/needed ect. Completion date: 9/25/2018	

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 _____	C 08/16/2018

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 880	Continued From page 84 bleach SaniWipes, allowed to air dry, and once dried, placed back into the cart. The DON stated pool staff were oriented to basic policies and procedures on the first day at the facility, however, upon review of the orientation checklist, this had not been completed. On 8/14/18, at 4:15 p.m. RN-F stated she had not been given orientation to the facility policy and procedures. An undated policy Cleaning, Disinfection and Sterilization identified each resident was to have their own glucometer. If a "house" glucometer were used on a resident, it was cleaned after each use with a disinfectant [unspecified] and the glucometer was to remain visibly wet for three minutes. A policy Monarch Healthcare Management Bloodborne Pathogens Exposure Control Plan revised in 2008, The policy indicated it was the employer responsibility to provide all employees with training and education regarding occupational exposure at the time of initial employment, with subsequent training conducted at least annually.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a	F 881		9/25/18

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 _____	C 08/16/2018

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 881	Continued From page 85 system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure urinary tract symptoms were appropriately treated for 1 of 1 residents (R29) reviewed for urinary tract infections (UTIs) Findings include: R29's 5 day PPS (Prospective Payment System) Minimum Data Set (MDS) dated 6/26/18, indicated R29 had moderate cognitive impairment. R29 was identified as receiving extensive assistance with toileting and had frequent episodes of urinary incontinence (accidents) with some continence present. The MDS identified R29 had multiple diagnoses which included: diabetes mellitus (a group of diseases that affect how your body uses blood sugar (glucose), chronic kidney disease, and an overactive bladder. R29's Medication Administration Record for August of 2018, indicted R29 received Levofloxacin tablet 750 milligram (mg) by mouth daily for five days starting on 8/10/18 and completed on 8/15/18. R29's urine culture results, collected 8/9/18 and reviewed 8/11/18 identified the culture was positive for 50,000 to 100,000 cfu/ml ((colony-forming units per milliliter) of candida albicans/c. dubliniensis (a mixed growth of yeast colonies in urine) as a presumptive identification. The document was time stamped 8/11/18 at 7:13 p.m. R29's progress notes identified the following:	F 881	R29 is no longer on antibiotics. For All current residents who have been identified for use of antibiotics, their assessments, interventions and plan of care have been reviewed and updated to reflect the proper use of antibiotics for infections. McGeer's criteria will be implemented for the resident prior to requesting the use of antibiotics from the providers. DON and MD will continue to provide ongoing education to nursing staff on Antibiotic stewardship and McGeer's criteria. The DON or designee will reeducate appropriate staff regarding Antibiotic Stewardship Program which is included in the Estates at Delano Infection Prevention and Control Program. This program will assure proper use of antibiotics are prescribed for the residents by the providers. The DON or designee will complete audits to assure proper use of antibiotics weekly X 4, and then monthly X 2. Audit results will be reviewed by the QAPI Committee for further recommendations. DON or designee will keep the infection control log updated to reflect illness/infections, antibiotic usage, trends and analysis of resident and employee's	

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 _____	C 08/16/2018

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 881	Continued From page 86 On 8/9/18, at 10:07 p.m. R29 was transferred to the ER following a fall because she was "agitated and anxious." On 8/10/18, at 1:30 a.m. R29 returned from the emergency room with orders for an antibiotic for a UTI. On 8/10/18 at 2:32 p.m. R29's provider was contacted regarding residents decline and new order for UTI. The note reflected resident was to continue on antibiotic orders for the UTI. On 8/11/18, at 9:54 p.m., a call was received from the hospital lab in follow up from the urine culture/urine analysis (U/A, U/C) which came back negative. The culture showed no bacterial growth, but did identify a yeast. The results were faxed to the provider for review as requested by the hospital lab. On 8/14/18, at 1:52 p.m. a Pharmacy Review of medications was completed. The progress notes from 8/101/8, at 1:30 a.m. to 8/14/18, at 1:52 p.m. did not identify any signs and symptoms of a UTI. On 8/16/18, at 11:48 a.m. licensed practical nurse (LPN)-A, care coordinator was unable to provide any documentation in the record to reflect the provider had reviewed the culture results and had chosen to continue with the antibiotics as ordered. LPN-A stated the information should be reflected in the medical record. On 8/16/18, the director of nursing (DON) stated the urine culture result for R29 was reviewed with	F 881	as well continue ongoing education to residents, families and staff on antibiotic stewardship. Director of Nursing or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process	

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 _____	C 08/16/2018

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 881	Continued From page 87 the provider and they wished to complete the antibiotic therapy. The DON was unable to provide documentation to reflect this conversation. The results of the culture were reviewed and the DON stated the results did reflect a yeast infection and not a bacterial infection. A facility policy dated 11/17, Antibiotic Stewardship Program indicated antibiotic stewardship was designed to optimize the treatment of infections while reducing adverse events associated with antibiotic use. The policy identified the Infection Preventionist, or designee, would review all antibiotic orders to determine if treatment is appropriate. The policy stated treatment was not appropriate if the organism was not susceptible to the antibiotic chosen. The provider was to be notified of the review findings and recommendations and a response would be documented in the resident's medical record.	F 881		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain carpet in a clean, sanitary manner in 2 of 2 hallways observed to have visibly stained carpeting. This had potential to affect all 38 current residents in the facility, visitors and staff who used the area on a routine basis.	F 921	All carpet areas of concern are being addressed to continue to remove any stains and maintain them in the best possible condition. Cleaning Schedule of carpeting has been implemented to assure carpeted areas are kept clean.	9/25/18

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 _____	C 08/16/2018

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 921	Continued From page 88 Findings include: On 8/14/18, at 2:45 p.m. the hallway carpeting on both the north and south hallways was observed. The hallway flooring was a thin, commercial grade carpet, predominantly brown in color, with tan and red-colors mixed in, and was found on both main hallways (about 8' wide) running the entire lengths, as well as in the entry/day room areas of the facility. The south hallway carpeting had numerous dark-stained spots of various shapes and sizes, as well as a urine odor, present where resident rooms begin and going toward the far end of hallway, away from the nursing station. Similarly, the north hallway's carpet had spots and discoloration of various sizes, lessening down the far end of the hallway, away from the nursing station. When interviewed on 8/16/18, at 11:41 a.m. housekeeper (HK)-A stated there were odors in the hallways, and "some resident rooms in particular." The carpets were stained, dirty and worn, and thought maintenance was cleaning them, but was unsure of any regular cleaning schedule. HK-A did not know when the flooring in either hallway, or the common areas was last cleaned. She stated, the maintenance person "just gave his notice" yesterday and she was not sure now who was going to be in charge. HK-A stated she freshened the smell in the rooms and hallway with a non-aerosol spray she had on her cleaning cart, "I use the spray to knock out the odors." A review of the flooring and carpets was made with the facility administrator on 8/16/18 at 11:45 a.m. During interview at 11:47 a.m. the administrator stated he did not know if there was	F 921	All residents have the potential to be affected if not provided a clean environment. Staff will be re - educated on the carpet cleaning schedule to ensure carpeted areas are kept clean. Staff will be re-educated on ensuring a clean and well-maintained environment. Audits of facility carpet cleanliness to be completed weekly x4, and then monthly x2. Three resident interviews of facility environment specific to cleanliness of carpeting will be completed weekly x4 weeks, and then monthly x2. Maintenance Director or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	

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 _____	C 08/16/2018

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 921	Continued From page 89	F 921		

or if there had been a schedule for the regular cleaning of the carpets, and since the maintenance man is no longer with us, "Ill have to check to see if he had a log." The administrator stated there had been some cleaning on certain sections of the carpet, and also some spot cleaning. The administrator any discussion of replacing a floor, maybe with something other than carpet "was on a higher level" and that would not be his decision. The administrator stated the carpet was in need of attention, and "I think it needs to be cleaned on a regular schedule."

During a subsequent interview on 8/16/18 at 2:50 p.m., the administrator stated he was not able to find any cleaning log, as evidence of when the carpets had been clean.

A facility policy regarding cleaning schedules and maintenance of floor/carpeting was requested, but none was provided.

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 _____	**08/14/2018**

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 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/13/2018

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 _____	**08/14/2018**

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 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 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	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 _____	**08/14/2018**

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 353	Continued From page 2	K 353		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 54 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 08/14/2018 documentation review revealed	K 353	The facility completed the 5-year obstruction inspection on 9/5/2018 Staff will be re-educated on ensuring the 5-year obstruction inspection maintenance/testing is completed Audits of the facilities 5-year obstruction inspection has been completed Maintenance director or designee will be responsible party QAA will provide redirection or change when necessary to ensure completion	9/25/18

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 _____	**08/14/2018**

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 353	Continued From page 3 the 5 year obstruction inspection has not been conducted. Last 5 Year inspection was 3/20/13. This deficient condition was confirmed by the Maintenance Director.	K 353	and/or continuation of monitoring process	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT 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 9:00 am to 1:00 pm on 08/14/2018, 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	K 521	The facility would like to request an updated waiver for the 8/14/2018 Life Safety Code Inspection. The facility 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 provision 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	9/25/18

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 _____	**08/14/2018**

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 4 for the bathrooms exhaust. This deficient condition was confirmed by the Maintenance Director. An annual waiver was previously granted.	K 521	integrity of the building would potentially be compromised by the installation of the required equipment. (See Attached Updated Waiver Request for NFPA 101 HVAC)	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to 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 54 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 08/14/2018 record review and staff interview revealed the 1st shift of the 4th quarter in 2017	K 712	The facility will complete and document fire drills at least quarterly on each shift. Staff will be re-educated on fire drill documentation and schedule. Audits of the facilities fire drills will be completed monthly x6 months, then as needed. Maintenance Director or designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	9/25/18

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 _____	**08/14/2018**

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 5 was missed. This deficient condition was confirmed by the Director of Maintenance.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 9:00 AM and 1:00 PM on 08/14/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the	K 901	The facility will complete a facility risk assessment. Staff will be re-educated on the facility risk assessment. Audit of the facilities risk assessment will be completed upon completion of the risk assessment and annually x1 year, then as needed. Maintenance Director of designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	9/25/18

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 _____	**08/14/2018**

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 901	Continued From page 6 Maintenance Director.	K 901		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		9/25/18

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 _____	**08/14/2018**

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 918	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 54 residents if the generator failed to operate during a power outage. Findings include: On the facility tour between 9:00 am to 1:00 pm on 08/14/2018 record review and staff interview revealed there was no record of the September 2017 weekly generator inspections. This deficient condition was confirmed by the Maintenance Director.	K 918	The facility will complete weekly generator inspections and document completion. Staff will be re-educated on completing weekly generator inspections and documenting weekly generator inspections. Audit of the facilities weekly generator inspections documentation will be completed weekly x4, and then monthly x2. Maintenance Director of designee will be responsible party. QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process.	