DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 27, 2025

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

RE: CCN: 245336
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 31, 2025, the Minnesota Departmen of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 16, 2025

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

RE: CCN: 245336
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT DELANO LLC	433 COUNTY ROAD 30 DELANO, MN 55328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/8/25 and 1/9/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53364342C (MN00109664, MN00109697) with a deficiency cited at F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610		1/24/25

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

Electronically Signed | 01/22/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

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F 610	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an abuse protection plan was documented and all staff were educated on the plan for 2 of 3 residents (R1, R2) reviewed for sexual abuse. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/4/24 indicated severe cognitive impairment with diagnoses including convulsions and Alzheimer's disease. R1's care plan dated 10/14/24 indicated R1 was a vulnerable adult with a goal of remaining free from abuse and/or neglect. An additional goal was added 1/7/24 directing R1 would be kept safe from other residents, and not be left alone with any other residents without staff supervision. R2's quarterly MDS dated 12/18/24 indicated severe cognitive impairment with diagnoses including dementia. R2's care plan indicated he was at risk for alteration in mood and behavior related to dementia. On 1/3/25 at 8:30 p.m., R1's incident note indicated R1 and R2 were sitting in their wheelchairs in the common area. At 8:30 p.m., another resident alerted staff R2 was lifting up	F 610	F610 s/s D - The process for satisfying this requirement has been reviewed and revised as needed, to ensure an abuse protection plan is documented and all staff are educated on the residents (R1, R2) reviewed for sexual abuse. - Failure to comply with this requirement had the potential to affect all residents of the facility. -R2’s Care plan was reviewed and revised as needed. -R1’s Care plan was reviewed and revised as needed. -R1 was evaluated, with monitoring initiated, and there have been no signs of adverse effects from the incident. -The Monarch Healthcare Management Abuse Prohibition/Vulnerable Adult Policy and literature on Minimizing the Risk of Resident-to-Resident Mistreatment in Post-Acute and Long-Term Care has been utilized as guidance for reeducation to necessary EAD staff; which includes, but is not limited to Monarch Float Pool staff.	

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F 610	Continued From page 2 R1's foot, then attempted to grope her. R2 put his hands up R1's shirt while asking her, "You like that?" Staff immediately separated R1 and R2. The administrator was notified. R1 was brought back to her room. She did not show any signs of anxiety, distress, or pain. No skin alterations were noted. R1's husband was notified. 15-minute checks and emotional distress monitoring were initiated. On 1/3/25 at 8:30 p.m., R2's incident note indicated R1 and R2 were sitting in their wheelchairs in the common area. At 8:30 p.m., another resident alerted staff R2 was lifting up R1's foot, then attempted to grope her. R2 put his hands up R1's shirt while asking her, "You like that?" Staff immediately separated R1 and R2. R2 was agitated and verbally aggressive towards staff. When asked about his behavior, R2 stated that he was trying to feel her breasts, "I know she liked it because she wasn't stopping me." R2 was brought to his room with 1 to 1 supervision until he went to bed at 9:30 p.m., then 15 minutes checks were utilized. On 1/8/25 at 1:23 p.m., R2's social worker note indicated R2's wife was concerned his behaviors were getting worse. R2's provider note dated 1/8/25 indicated R2 was experiencing behavior issues lately. R2 had an episode where he placed his hands up the shirt of another resident, had tried to hit another resident, and was agitated and restless. No physical changes were noted. A new order was placed for Seroquel (a medication used to treat agitation in people with dementia) 12.5 milligrams (mg) two times a day for dementia with agitation.	F 610	-TMA-A, NA-A, and NA-B, members of the Monarch Float Pool, have been, or will be, reeducated to this requirement again prior to their next shift. -The NAR care guide was updated, as identified in the 2567, to reflect necessary changes post incident. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Administrator or designee is responsible party. -Corrective action will be completed on or before 1/24/25	

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F 610	Continued From page 3 NA care sheet dated 12/24/24 lacked information about keeping R1 and R2 separate. NA care sheet dated 1/9/25 included new information for R2 included keep supervised around women and cannot be left alone with R1. New information for R1 included keep R1 away from R2. On 1/8/25 at 1:45 p.m., nursing assistant (NA)-A stated she worked with the float pool and had not worked at the facility recently. She gave R1 a bath the morning of 1/3/25, then took R1 to the common area to watch television with R2. Other staff members told her R1 could not be alone with R2, so NA-A moved R1. She did not receive information in report, nor was she educated before her shift, and there was no information on the nursing assistant care sheet about keeping R1 and R2 separated. As a person who did not work at the facility frequently, she relied on the NA care sheet for information. On 1/8/25 at 2:35 p.m., NA-B stated she worked with the float pool and had worked several shifts recently. She uses the NA care sheets for information about residents, and did not know where to look in the computer to find any resident specific interventions. She had not received any education about R2. On 1/8/25 at 4:23 p.m., trained medication aide (TMA)-A stated she worked with the float pool and had worked several shifts recently. She received information through report to keep R1 and R2 separate, but did not know if it was written down anywhere. She had not received any education about R1 and R2 in the last week. On 1/8/25 at 4:38 p.m., R1's significant other (SO) stated he had not had any concerns about	F 610		

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F 610	Continued From page 4 R2 before this incident, but now he did not want R1 to be around R2. R1 was unable to communicate verbally, and did not have any purposeful movements. If R1 had the capability, she would have punched R2 for touching her. She would not have liked any man other than himself touching her. On 1/9/25 at 1:23 p.m., the director of nursing (DON) stated psychology services were declined by R1 and R2's decision makers due to their respective cognitive status. Psychology services was consulted about the situation and recommended staff-based interventions. These included staff to keep R1 and R2 separate at all times. This intervention was communicated to staff through education and shift to shift report. It was also on the NA care sheets and in both resident's care plans. The DON confirmed the intervention to keep R1 and R2 separate was not on the current NA care sheets, and the information in R2's care plan stated to not leave him alone with another resident. On 1/9/25 at 2:38 p.m., the administrator confirmed the intervention on the new NA care sheet and in R2's care plan instructed staff to not allow R2 to be alone with another resident. It would not be safe to place R1 next to R2 even when supervised. The intervention should instruct staff to not allow R1 and R2 to be close to each other. The administrator confirmed the intervention needed to be clarified. She verbally educated NA-A and NA-B. The facility Abuse Prohibition/Vulnerable Adult Policy dated 3/24 directed the purpose of the policy is to protect residents against abuse by anyone. The policy instructed staff will take	F 610		

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F 610	Continued From page 5 necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. Further instruction included the facility will provide proper follow up communication related to the incident across all shifts.	F 610		

DEPARTMENT OF HEALTH

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Electronically delivered

January 16, 2025

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

Re: Event ID: C5KU11

Dear Administrator:

The above facility survey was completed on January 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/8/25 and 1/9/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H53364342C (MN00109664, MN00109697).	2 000		

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2 000	Continued From page 1 NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		