

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER The Estates at Delano LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 433 County Road 30 Delano, MN 55328	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083</p> <p>Based on interview and document review, the facility failed to report an allegation of sexual abuse to law enforcement as required for 1 of 1 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included bipolar disorder, anxiety disorder, and post traumatic stress disorder. Identified R1's cognition was intact.</p> <p>R1's care plan dated 10/23/24, revealed R1 required assistance of one to two staff members for activities of daily living (ADLs) such as dressing, personal hygiene, and toileting.</p> <p>Review of facility report number 358352 to the State Agency (SA) dated 10/21/24 at 12:40 p.m., revealed R1 reported nursing assistant (NA)-A came into her room to assist R1 with brief change and while wiping R1's bottom, R1 reported feeling NA-A place her hand in R1's vagina. R1 reported the incident shocked her and hurt her.</p> <p>R1's progress note dated 10/23/24 at 1:35 p.m., revealed R1 met with administrator and director of nursing (DON) and asked staff to call 911 so she can make a report about the incident brought to staff's attention on 10/21/24. 911 was called and R1 requested facility social services director attend the meeting with the police department when R1 would give a statement. 911 dispatcher confirmed someone would meet the resident in her room to complete a report. Further, handwritten on the progress note indicated police were called on 10/23/24 at 1:31 p.m. and the police arrived at the facility at 2:35 p.m.</p> <p>On 10/23/24 at 2:57 p.m., sheriff deputy (SD)-A entered the conference room and introduced self to SA. SD-A stated he was contacted through the dispatch at 1:44 p.m., to come to the facility and meet with R1 regarding the allegation. SD-A stated dispatch received a call from the facility at approximately 1:30 p.m.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 3:10 p.m., R1 observed sitting in a wheelchair in her room. R1 stated she had been residing in the facility for approximately three months and had received the best care until the incident on the morning of 10/20/24. R1 stated she was laying in her bed in her room and was utilizing the bed pan to have a bowel movement. R1 put on her call light for assistance with hygiene cares and NA-A entered her room, rolled R1 onto her side so she was facing the wall and NA-A had started wiping her bottom real hard and NA-A was wiping in the crevices of her butt and that was when NA-A went further into my legs and put her finger in my vagina and turned her finger so I could feel it and that hurt. Further, R1 stated she felt uncomfortable and NA-A then stormed out of R1's room and R1 laid there.</p> <p>On 10/25/24 at 10:11 a.m., social services director (SSD) stated R1's cognition was not impaired and R1 would report any concerns she had verbally to staff or would file a grievance, but R1 had never reported concerns related to abuse previously. SSD stated she was made aware of R1's allegation on 10/21/24, right before noon meal. SSD stated R1 had reported to her concerns regarding NA-A had inserted her hand into R1's vagina. Further, SSD stated the administrator and DON were notified. SSD stated the police were not notified at that time and SSD stated she was not aware of the facility's policy related reporting to law enforcement. In addition, SSD stated she wished she would have offered to call law enforcement then but was focused on helping R1 with her emotions.</p> <p>On 10/25/24 at 10:28 a.m., DON stated she was made aware of R1's allegation on 10/21/24, in the morning but was uncertain what time, by human resources. DON stated R1 had reported NA-A put their entire hand up R1's vagina. DON stated the allegation was reported to the SA on 10/21/24, within two hours and at that time R1 had also declined going to the hospital for an evaluation. Further, DON stated on 10/23/24, staff had asked R1 if she would like to file a police report which R1 had stated yes. DON stated she was not aware of the facility's policy on when to report allegations to law enforcement and stated she would have to look at the policy, but on 10/21/24, when R1 reported the allegation it didn't dawn on us at that time.</p> <p>On 10/25/24 at 10:57 a.m., administrator stated she was made aware of R1's allegation on 10/21/24, at 11:20 a.m. DON stated the allegation was reported to the SA and staff had asked R1 if she wanted the facility to call or tell anyone else, which included the police, and R1 had said no. Administrator stated on 10/23/24, staff had asked R1 again if she would like the police to be notified and she stated yes, so that was when the facility notified law enforcement. Administrator stated she was unaware of the facility's policy for reporting to law enforcement, but in the past it has been up to the resident. In addition, administrator stated offering to notify law enforcement of an allegation of sexual abuse should be offered and if there was suspicion of any crime the facility should be reporting it to law enforcement.</p> <p>Review of facility policy titled Reporting Suspicion of a Crime revised on 2/2024, indicated the administrator, DON, or any other designated individual would report (within the required time frames) any reasonable suspicion of a crime against a resident to the State Agency and local law enforcement. Further, the policy revealed examples of crimes that would be reportable in any jurisdiction which included sexual abuse. The timing of reporting would be based on the events that cause suspicion would be as follows: if the event resulted in serious bodily injury which was defined as an injury involving serious physical pain, substantial risk of death, sexual abuse or aggravated sexual abuse, the suspicion would be reported immediately but not more than two hours after the individual first suspects that a crime had occurred.</p>		