

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 01/09/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48300</p> <p>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.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated severe cognitive impairment with diagnoses including convulsions and Alzheimer's disease.</p> <p>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.</p> <p>R2's quarterly MDS dated [DATE] indicated severe cognitive impairment with diagnoses including dementia.</p> <p>R2's care plan indicated he was at risk for alteration in mood and behavior related to dementia.</p> <p>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 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.</p> <p>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.</p> <p>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.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>On 1/8/25 at 4:38 p.m., R1's significant other (SO) stated he had not had any concerns about 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p>		