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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Delano LLC	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure the Minnesota Ombudsman Office was informed of residents discharging against medical advice (AMA) for 2 of 3 residents (R37 and R38) who were reviewed for discharge from the facility.Findings include - R37: R37's electronic medical record (EMR) documented the following diagnoses: multiple fractures of ribs, left side subsequent to a motor vehicle accident, acute pain from trauma and muscle weakness. R37 was admitted to the facility on [DATE] and discharged against medical advice on 10/01/25, after not returning from an leave of absence (LOA). Review of R37's progress notes documented the following: > 9/30/2025 [9:45 p.m.] Writer was told in report resident was on LOA and will be back, around 9PM resident was not available, writer called resident phone and left a voicemail for resident to call facility> 10/01/2025 11:00 a.m., [business office manager] resident and left called a VM regarding his failure to return from LOA. Resident signed out and left the faciity on 9/30/25 at about 1:30pm stating that he would return in a couple hours. Resident still has not returned call. [business office manager -BOM] also called resident's friend who did not answer. BOM left VM and a return call has not yet been made.> 10/01/2025 11:28 a.m., [social services designee] called resident phone number and resident's friend, [Friend-A], phone number. No answer. [social services designee] requested resident/[Friend-A] call the facility to give an update on whereabouts> 10/01/2024 12:41 p.m., Administrator called resident's phone and left a voice message. Administrator called resident's [Friend-A], Friend-A returned call quickly and stated that resident is an adult and able to make his own decisions. [Friend-A] stated that he brought resident home and left. [Friend-A] stated that resident stated he was going to stay home and not return to the facility. [Friend-A] encouraged resident to call facility to let them know. Facility has not received a call back from resident. [Friend-A] stated that he was going to go to resident's house to check on him. [Friend-A] plans to update Administrator.> 10/01/2025 1:17 p.m., Administrator received return call from resident's friend [Friend-A]. [Friend-A] was able to get a hold of resident and instructed him to call The Estates at [NAME]. [Friend-A] confirmed that resident is at home and staying at home. Administrator was not able to speak with resident directly, so three additional calls were made to resident. Resident did not answer. Resident still has not made contact with facility.> 10/01/2025 4:44 p.m. At 2:20pm, Administrator and [social services designee] called 911 and requested a wellness check on resident at his personal address. 911 operated stated if resident was not found at address, a missing person's report will be filed. MAARC report was filed. Ombudsman notified. MAARC confirmation number: 1000244718.> 10/01/2025 at 5:12 p.m., [social services designee] attempted to call resident. No answer. [social services designee] left another voicemail.> 10/01/2025 6:25 p.m., Administrator called [NAME] County Sheriff's department for an update on wellness check. Sheriff stated that the officer that was on call during the wellness check was not able to make contact with resident. Sheriff stated that it was written in the notes, person working at business hasn't seen him in a month. Sheriff was unable to state what the business was or who the business person was. Sheriff reached out to the Sheriff on duty during the wellness check. The sheriff called administrator back and stated that (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the officer that was on duty stated it is an apartment building attached to a business. There is a person at front desk monitoring ins and outs, and they had stated that they have not seen this resident for a month. Administrator told sheriff that she would be filing a missing persons report. Sheriff agreed and instructed administrator to do so with [NAME] County.> 10/01/2025 6:53 p.m., Administrator filed missing person report #25027552 with [NAME] County Sheriff Department.> 10/01/2025 7:11 p.m., [Deputy-A] arrived to facility and called Administrator for more information. [Deputy-A] stated he was going to try to find resident tonight and would update administrator with additional details.> 10/01/2025 8:20 p.m., [Deputy-A] called administrator stating that [R37] has been found safe at home. [R37] returned administrator's call stating he would like to be discharged AMA from The Estates at [NAME]. MAARC completed by SS 10/1/2025. Administrator discharged resident at 8:22pm. During interview on 11/18/2025 at 4:21 p.m., the facility assigned ombudsman (OMBUD)-A, after referencing her records, stated she had received an email from the social service designee (SSD) on 10/01/25 at 2:52 p.m., indicating R37 had left the facility yesterday with a friend and never returned. The email indicated they had involved the police to do a wellness check and had filed a MAARC (Minnesota Adult Abuse Reporting Center) report with the state of Minnesota. OMBUD-A stated she was uncertain if the facility had included R37 in their monthly report to the Office of Ombudsman but would check with the office's staff. On 10/01/2025 at 5:01 p.m., survey received a TEAMS Chat message indicating the facility had not included R37's AMA discharge to the Office of Ombudsman. R38: R38's electronic medical record (EMR) documented the following diagnoses: urinary tract infection, morbid obesity, muscle weakness, unsteady on feet and history of falling. R37 was admitted to the facility on [DATE] at approximately 4:00 p.m., and discharged against medical advice on 10/24/24 at approximately 12:00 p.m. (approximately 44 hours after admission) with family. A review of R38's Discharge Planning (dated 10/23/24) INDICATED: Resident would like to recover from his fall and return home with spouse. In review of R38's electronic medical record progress notes, the following was documented: > 10/24/2024 10:12 a.m. Behavior Note Text: Met with resident this morning after hearing that he was more confused during the night and was out in the hallway nude. [Director of nursing] confirmed with staff that they saw the Resident come out of his room nude. They immediately intervened and brought him back to his room and got him dressed. The resident stated that he is not sure how he became nude. He stated I found a door to go out of and then I was in a long hallway. People were in the hall. They found me these clothes. I don't know how they got on me or how they got here, but I recognize the pants. When asked if he slept in his bed or in the chair last night, the resident stated that he did sleep some in his bed but also got up into the chair. [Director of nursing] attempted to notify [(Fam)-A], with Resident's permission. Fam-A had called the facility concerned about her father's behaviors. DON left a voicemail for Fam-A to call back when she was able.> 10/24/24 at 12:02 p.m. Resident's [family] arrived at facility. DON, Administrator, and SSD spoke with family to update them on how resident was doing and to answer any questions. Family was concerned resident should go to hospital. Staff assured family resident was safe at facility and if staff noted any concerns, the facility would send resident to the hospital. Family did not agree and requested to discharge resident AMA. [Director of nursing] and Administrator educated family on the risks of discharging AMA. Family understood but decided to d/c AMA. Staff interviewed resident to ensure resident was okay. Resident stated he did not mind being at the facility but wanted to please his wife and daughter and do what they asked. Family signed AMA paperwork. Family stated they would be bringing resident to the hospital.> 10/24/24 at 12:55 p.m. MAAR report filed due to resident leaving AMA. Thu [DATE] 12:53:50 confirmation number: 1000204449 During interview on 11/18/2025 at 4:21 p.m., the facility assigned ombudsman (OMBUD)-A, after referencing her records, stated she had received an email from the social service designee (SSD) on 10/24/24 at 12:55 p.m., indicating R38 had left the facility AMA and the facility had filed a MAARC report. OMBUD-A stated she was uncertain if the facility had included R38 in their monthly report to the Office of Ombudsman but would check with the office's staff. During interview on 11/19/25 at 10:48 a.m., SSD stated she (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had contacted OMBUD-A on both R37 and R38 via email, which were provided. However, when SSD reviewed the monthly reports sent to the Office of Ombudsman (copies kept in a three ring binder), which should have included both residents names, dates of discharges and reason for the discharges, SSD not R37's and R38's names were not included. SSD stated the program they use requires her to trigger filters to gather the names and reasons for facility discharges. SSD stated the filter for AMA had not been selected, when the reports for R37 and R38 were run. In review of the requested facility policy for reporting discharges to the the Office of Ombudsman, the facility provided the policy entitled: Ombudsman Hospital Transfer Report (dated 08/2025). The policy documented the following: Purpose -Copies of notices for emergency transfers must be sent to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis. Procedure - 1. This report is sent monthly, typically within the first 5 days of the month for the previous month.2. Run the report on [Point Click Care - PCC], using the following instructions: a. In PCC, go to Admin tab b. Reports c. Action Summary Report d. Ensure you date range is correct e. Action Code - Clear it all and then scroll to the bottom and click i. Transfer out to hospital ii. :discharge date iii. Discharge/Transfer New Facility f. Ensure all Payer Types are selected g. Click Show to / from description h. Run report3. Fax printed report to the Ombudsman at [PHONE NUMBER]\4.4. Once faxed, print and fax confirmation5. Keep the Fax Cover Sheet, Report and Fax Confirmation together in a file folder or binder.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure there were orders and interventions in place for continuous positive airway pressure (CPAP) machine usage for 1 of 1 residents (R16) reviewed for CPAP therapy. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R16 was cognitively intact and required assistance with all cares. Diagnoses included congestive heart failure (CHF), diabetes, atrial fibrillation, chronic kidney disease, end stage renal disease, obstructive sleep apnea, chronic respiratory failure and asthma. R16's care plan initiated 7/9/25, identified R16 had an alteration in oxygen/gas exchange, respiratory status related to sleep apnea and chronic respiratory failure. Interventions included CPAP at bedtime for sleep apnea. R16's physician orders dated 11/17/25 failed to indicate orders to wear CPAP machine at night, clean CPAP mask and tubing or to replace CPAP supplies. On 11/17/2025 at 11:12 a.m., R16's CPAP machine was observed on pole, the tubing was draped over the machine, the face mask was noted to have an unknown brown, crusty substance around the perimeter of the cushion. When interviewed on 11/17/25 at 4:55 p.m., R16 stated she wore her CPAP every night, needed assistance from staff to put the mask on. R16 was not sure when the mask and tubing were cleaned by staff. On 11/19/2025 at 11:23 a.m., observed R16's CPAP tubing was draped over the bottom rail of the bed with the CPAP mask facing the floor about six inches from the floor with the headgear resting on the floor under the bed. The CPAP mask was noted to have an unknown dried, white substance on the cushion. When interviewed on 11/19/2025 at 1:34 p.m., nursing assistant (NA)-A stated R16 wore the CPAP every night, needed assistance to put it on. NA-A stated the nurses took care of the CPAP machine. NA-A she R16 wore her CPAP every nightWhen interviewed on 11/18/2025 at 1:42 p.m., PM NA-B stated the nurses took care of the CPAP machine, but the nursing assistants helped her put the mask on when R16 went to bed. NA-B stated R16 wore the CPAP every night. When interviewed on 11/18/2025 at 1:45 p.m., registered nurse (RN)-A stated there should be orders in R16's electronic medical record (EMR) for R16 to wear the CPAP every night, cleaning the tubing and mask and replacing supplies. RN-A was not able to locate any orders regarding R16's CPAP in the EMR. RN-A was not sure when the CPAP tubing and mask were cleaned but knew another nurse had recently replaced the maskWhen interviewed on 11/18/2025 at 1:55 p.m., director of nursing (DON) stated there should be orders in the EMR for CPAP. DON was not certain why there were no orders located in R16's EMR. Facility policy regarding CPAP machines was requested, however, none was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure there were orders in place for Dexcom sensor (a wearable Continuous Glucose Monitoring (CGM) system for people with diabetes) for 1 of 3 residents (R16) reviewed for Dexcom use. In addition the facility failed to ensure orders were in place to remove pressure dressing (bandage applied to stop bleeding) after dialysis (medical procedure filters and removes waste from blood) for 1 of 1 residents (R16) reviewed for dialysis. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R16 was cognitively intact and required assistance with all cares. In addition the MDS indicated R16 received dialysis. Diagnoses included congestive heart failure (CHF), diabetes, atrial fibrillation, chronic kidney disease, end stage renal disease, obstructive sleep apnea, chronic respiratory failure and asthma. Review of R16's progress notes identified nurses had replaced R16's Dexcom sensor on 9/23/25, 10/4/25, 10/17/25 and 11/17/2025. R16's orders dated 11/17/25, directed nurses to monitor R16 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) and to check blood sugars four times daily. However, R16's electronic medical record (EMR) failed to contain orders to change R16's Dexcom every 10 days. R16's orders directed staff to obtain vital signs after dialysis and monitor site every shift for bruit (listening for turbulent blood flow) and thrill (feel for vibration of blood flow) however, the R16's EMR failed to contain orders to remove the pressure dressing following dialysis. R16's care plan initiated 5/2/25, indicated R16 was at risk for complications related to dialysis with interventions which included dialysis per schedule and treatment and dressing protocol to dialysis site per order. When interviewed on 11/17/25 at 4:55 p.m., R16 stated the nurses check her blood sugars with the use of her Dexcom sensor. R16 further stated facility staff did not remove the pressure dressing from the dialysis fistula (dialysis access) site, she removed the dressing herself the day after receiving dialysis. When interviewed on 11/18/2025 at 1:45 p.m., registered nurse (RN)-A stated there should be orders in R16's EMR to have the Dexcom sensor replaced every 10 days. RN-A was not able to locate any orders regarding R16's Dexcom application in the EMR. When interviewed on 11/18/2025 at 1:55 p.m., director of nursing (DON) stated there should be orders in the EMR to change R16's Dexcom sensor, DON was unable to locate an order and was not sure how the nurses had changed the Dexcom when there was not order in the EMR for them to do so. When interviewed on 11/18/25 at 1:55 p.m., RN-B was not sure about an order to removed R16's pressure dressing after dialysis, has removed it at times but not on a regular basis. When interviewed on 11/18/25 at 2:30 p.m., DON stated there was an order to monitor every shift for bruit and thrill in R16's EMR, but was unable to locate an order to remove the pressure dressing and would have to check into that. During follow-up interview on 11/18/25 at 2:40 p.m., DON stated R16 had previously been admitted to the hospital, all orders had been discontinued at that time. The Dexcom order had not been re-started upon R16's return to the facility. DON stated checked on removal of dressing, should be removed four to six hours after dialysis. DON was not sure why R16 did not have an order to remove the dressing. Facility policy regarding Dexcom and/or CGM use was requested however, was not provided. Facility Hemodialysis policy dated 11/22/19 was provided, however, the policy does not address removal of pressure dressing after dialysis.