STATE LICENSING COMPLIANCE REPORT

Report #: HL33426013C

Date Concluded: January 27, 2022

Name, Address, and County of Facility Investigated:
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Jeri Gilb, RN, MSN, CNP
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	C 01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	**1420 2ND STREET NORTH SAUK RAPIDS, MN 56379**

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER INITIAL COMMENTS: #HL33426008C, #HL33426010C and #HL33426013C On January 5, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. The following correction orders are issued for #HL33426008C and #HL33426010C, tag identification 0320. The following correction order is issued for #HL33426013C, tag identification 1070.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 ******REVISED TO INCLUDE NON-IMMEDIATE ORDERS****** INITIAL COMMENTS: Compliance Projects: #HL33426004C, #HL33426006C and #HL33426012C On January 12, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 17 residents receiving services under the provider's Assisted Living license. The following immediate correction orders were issued on January 12, 2022, 2:42 p.m. for #HL33426004C, #HL33426006C and #HL33426012C, tag identification 0110, 0490, and 2310. On January 14, 2022, the Minnesota Department of Health conducted a visit verify compliance of immediate correction issued for #HL33426004C, #HL33426006C and #HL33426012C and findings are as follows: The immediacy of correction orders, tag identification 0110, 0490 and 2310 were removed. The facility was also in compliance with correction orders, tag identification 0490 and 2310. However, non-compliance remains for correction order, tag identification 0110, at a widespread scope, level F.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 2 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all seventeen (17) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: A review on January 12, 2022, at 11:00 a.m., the Minnesota Board of Executives for Long-Term Services and Support website indicated housing manager (HM)-A was not listed as possessing a current LALD license. During an interview on January 12, 2022, at approximately 11:15 a.m., HM-A confirmed her education for LALD licensure and application was pending. During an interview on January 13, 2022 at approximately 09:30 a.m., HM-A stated her mentor, LALD-E and/or owner (OW)-D were	0 110		

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0 110	Continued From page 3 acting directors for the licensee's establishment until HM-A obtained licensure. During an interview on January 13, 2022 at approximately 11:04 a.m., regional director (RD)-C stated LALD-E was acting director for the licensee's establishment until HM-A obtained licensure. A review on January 13, 2022, at 11:00 a.m., the Minnesota Board of Executives for Long-Term Services and Support website indicated LALD-E was licensed as a LALD with an end date of September 15, 2021. The same source indicated OW-D was not listed as having a current LALD license. During an interview on January 13, LALD-E stated, "No, I'm not the acting LALD" for the licensee's establishment. LALD-E stated he worked for the licensee as a contracted employee, and only mentored HM-A, out of the licensee's Rochester office. LALD-E stated he resided in Wisconsin. Licensing follow up survey conducted on January 14, 2021, revealed the licensee failed to ensure employment of a licensed assisted living director (LALD) During an interview on January 14, 2021, at 11:00 a.m., RD-C said LALD-G was acting director for the licensee's establishment until HM-A obtained licensure. RD-C said the licensee was awaiting the Minnesota Board of Executives for Long-Term Services and Support's approval for a waiver, as LALD-G resided outside the required 60-mile radius from the licensee's establishment, and was not classified as HM-A's mentor. RD-C stated the licensee submitted waiver paperwork for LALD-G	0 110		

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0 110	Continued From page 4 on January 14, 2021. During an interview on January 14, 2021, at 2:20 p.m., LALD-G said she resided in Wisconsin and she was not aware of the Minnesota Board of Executives for Long-Term Services and Support waiver process. A review on January 14, 2022, at 2:30 p.m., the Minnesota Board of Executives for Long-Term Services and Support website indicated LALD-G was licensed as a LALD. The website indicated LALD-G was the director on record for the licensee's establishment, with a start date of January 14, 2022. The website indicated the board administratively approved and or denied waiver requests at board meetings and the next board meeting was scheduled for January 26, 2022. The licensee's policy related to Licensed Assisted Living Directors was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of this order was not removed at the time of exit on January 14, 2022.	0 110		
0 320 SS=D	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter.	0 320		

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0 320	Continued From page 5 (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee did not provide requested necessary resident and staff records to determine compliance to licensure laws and rules. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: Resident (R)1's medical records indicated diagnoses of atrial fibrillation, epilepsy, anxiety, depression, and intracranial injury. R1's undated service plan indicated the resident required assistance with medication administration, behavior management, meal	0 320		

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0 320	Continued From page 6 preparation, housekeeping, and laundry. R2's medical records indicated diagnoses included diabetes mellitus 2, obesity, irritable bowel syndrome, major depressive disorder and anxiety. R2's undated service plan indicated the resident required assistance with medication administration, support stocking assistance, behavior management, meal preparation, housekeeping, and laundry. During an onsite investigation January 5, 2022, the facility did not provide requested records. The housing manager (HM)-E stated she would email records by noon January 6, 2022. No records were received January 6, 2022. This investigator contacted the regional director (RD)-D for records on January 7, 2022, January 10, 2022, January 11, 2022, January 20, 2022, and January 21, 2022, however, the requested documentation was not provided. The facility did not produce R1's medication error reports or incident reports for missed warfarin on November 1 through November 5, 2021, medication administration record for November 2021, or termination notice for R1 in December 2021. The facility did not produce staff training documentation for R2's compression stockings or wraps. The facility did not produce alleged perpetrator (AP) 1's employment file, training records, discipline and termination documentation.	0 320		

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0 320	Continued From page 7 During an interview on January 20, 2022, at 2:02 p.m., RD-D stated the facility could not locate the above documentation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 320		
0 490 SS=I	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access	0 490		

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0 490	Continued From page 8 to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all seventeen (17) residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked staff access to an on-call RN, 24 hours per day, seven days per week. On January 12, 2022, at approximately 11:00 a.m., the surveyor observed the licensee did not have an RN on site and Housing manager (HM)-A was a licensed practical nurse (LPN). On January 12, 2022, at approximately 11:15 a.m., the surveyor observed the licensee failed to post names and phone numbers for unlicensed staff to contact the RN for consult. During an interview on January 12, 2022, at approximately 11:05 a.m., HM-A stated RN-B visited the licensee's establishment four times per week. HM-A also stated RN-B was the on-call nurse for the licensee's establishment, 24 hours per day, 7 days per week. HM-A confirmed the licensee did not post RN contact information readily for unlicensed staff to contact the RN for consult.	0 490		

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0 490	Continued From page 9 During an interview on January 12, 2022, at approximately 2:40 p.m., RN-B stated she terminated her employment with the licensee on December 31, 2021 and was asked to stay "as needed" in a different role. RN-B stated she did not receive a subsequent offer letter from the licensee regarding her new role. RN-B stated she was no longer the on-call nurse for the licensee's establishment. During an interview on January 12, 2022, at approximately 4:00 p.m., HM-A stated she was incorrect and RN-B was not the on-call RN. HM-A stated RN-F was the on-call nurse for the licensee's establishment. HM-A stated she did not recall RN-F's last name and did not have RN-F's phone number. During an interview on January 13, 2022, at approximately 10:04 a.m., regional director (RD)-C stated RN-F was an on-call nurse for the licensee's establishment, and RN-F was a licensed RN in Florida and not licensed in Minnesota. During an interview on January 13, 2022, at approximately, 11:09 a.m., RN-F stated she was hired by the licensee as an RN consultant to perform policy reviews and quality assurance assessments. RN-F stated she did not receive calls from the licensee's staff for consult. RN-F confirmed she was licensed in Florida and not licensed in Minnesota. The licensee's policy related to RN availability was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 490		

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01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee infringed upon one of one resident's (R1's) right to return to the facility after hospitalization without providing a written notice of termination. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Findings include: Resident (R)1's undated admission assessment indicated diagnoses of atrial fibrillation, epilepsy, anxiety, depression, and intracranial injury. R1's undated service plan indicated the resident required assistance with medication administration, behavior management, meal preparation, housekeeping, and laundry. R1's hospital medical records dated December 18, 2021, indicated R1 was combative and	01070		

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01070	Continued From page 11 aggressive at the ED. The hospital admitted R1, who underwent both psychiatric and neurology evaluations, resulting in medication changes and adjustments during his hospitalization. R1's behavior improved with the medication changes and R1 had no further aggressiveness or suicidal and homicidal ideation. R1's progress notes dated December 21, 2021 indicated R1 exhibited aggressive behaviors and actions on December 18, 2021. Facility staff contacted 911 after R1 verbalized suicidal ideation. When police and EMS arrived, he threatened to kill the staff who called 911. Emergency Medical Services transported R1 to the Emergency Department (ED) in restraints. The progress note indicated the facility then began paperwork for the resident's termination due to threats towards staff and other residents. During an interview on January 20, 2022 at 2:02 p.m., Regional Director (RD)-D stated the facility didn't have the supervision levels to monitor R1's aggression on return from the hospital. Although facility administration understood R1 should be able to return to the facility, the other residents expressed fear about R1 returning. The well-being of the other residents took precedence over R1 returning to the facility. RD-D stated R1 had verbal aggression, yelling, and threatening behaviors prior to this incident and the resident had threatened to kill staff previously. The facility Contract Termination policy dated 2021, indicated the facility may initiate an expedited termination of housing or services if the resident has engaged in conduct that substantially interferes with the rights, health, or safety of other residents or substantially and intentionally interferes with the safety or physical	01070		

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01070	Continued From page 12 health of facility staff. It also stated Cornerstone Management Services may not terminate the assisted living contract if the underlying reason for termination may be resolved by the resident obtaining services from another provider of the resident's choosing and the resident obtains those services. Expedited termination will provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. The notice for termination, for any reason, will contain, at a minimum: The effective date of the termination of the assisted living contract; a detailed explanation of the basis for the termination, including the clinical or other supporting rationale; a detailed explanation of the conditions under which a new or amended contract may be executed; a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request will be submitted and the contact information for the agency to which the request will be submitted; a statement that the facility will participate in a coordinated move to another provider or caregiver; the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination; information on how to contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination; information on how to contact the Senior LinkAge Line, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.	01070		

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01070	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	01070		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for eight of eight residents (R1, R2, R3, R4, R5, R6, R7, R8) who utilized bed rails with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The Food and Drug Administration (FDA), Side Rail Entrapment Zones and Dimensional Recommendations, dated March 10, 2006, indicated to reduce the risk of entrapment, zone 1 (space within the rail), zone 2 (under the rail), and zone 3 (between the rail and the mattress) should be less than 4 and ¾ inches. The FDA document	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	C 01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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02310	Continued From page 14 also indicated zone 4 (under the rail, at the end of the rails) should be less than 2 and 3/8 inches." The FDA's "A Guide to Bed Safety," revised April 2010, indicated, "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high risk patients. The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help determine how best to keep the patient safe." R1 R1 admitted for assisted living services with diagnoses including obesity and oxygen dependency for shortness of breath. R1's record lacked a bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:00 a.m., R1's bed was observed with a unilateral half side rail. R1's bed rail was observed to have an open space in zone 1, which measured 17 ½ inches, outside of FDA guidelines. During an interview on January 12, 2022, at approximately 2:42 p.m., housing manager (HM)-A confirmed R1's record lacked a bed rail assessment and lacked documentation of the risks versus benefits of bed rail use.	02310		

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02310	Continued From page 15 R2 R2 was admitted for assisted living services with diagnoses including dementia and anxiety. R2's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:10 a.m., R2's bed was observed to have bilateral, half side rails, attached to a hospital bed. R2's bed rails were observed wobbly (not tightened) and would create a space in zones 2 and 3 greater than 4 ¾ inches when pushed gently by the resident. During an interview on January 12, 2022, at approximately 2:42 p.m., HM-A confirmed R2's record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. R3 R3 was admitted for assisted living services with diagnoses including memory loss and lumbar disc disease. R3's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:20 a.m., R3's bed was observed to have bilateral side rails, attached to a hospital bed. During an interview on January 12, 2022, at approximately 2:42 p.m., HM-A confirmed R3's	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	**1420 2ND STREET NORTH SAUK RAPIDS, MN 56379**

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02310	Continued From page 16 record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. R4 R4 was admitted for assisted living services with diagnoses including seizure disorder and epilepsy. R4's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 22, 2022, at approximately 11:30 a.m., R4's bed was observed to have bilateral, half side rails, attached to a hospital bed. During an interview on January 22, 2022, at approximately 2:42 p.m., HM-A confirmed R4's record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. R5 R5 was admitted for assisted living services with diagnoses including seizure disorder. R5's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:30 a.m., R5's bed was observed to have bilateral side rails, attached to a hospital bed. During an interview on January 22, 2022, at	02310		

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02310	Continued From page 17 approximately 2:42 p.m., HM-A confirmed R5's record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. R6 R6 was admitted for assisted living services with diagnoses including cerebral infarction and compression fractures. R6's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:35 a.m., R6's bed was observed to have an attached "halo" side rail. R6's bed rail, zone 1, measured 12 ½ inches, outside of FDA guidelines. During an interview on January 12, 2022, at approximately 2:42 p.m., HM-A confirmed R6's record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. R7 R7 was admitted for assisted living services with diagnoses including glaucoma and depression. R7's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:45 a.m., R7's bed was observed to have attached bilateral side rails.	02310		

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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02310	Continued From page 18 During an interview on January 12, 2022, at approximately 2:42 p.m., HM-A confirmed R7's record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. R8 R8 was admitted for assisted living services with diagnoses including multiple sclerosis and narcolepsy. R8's record lacked a completed bed rail assessment and documentation of the risks versus benefits of bed rail use. During an observation on January 12, 2022, at approximately 11:50 a.m., R8's bed was observed to have attached bilateral side rails. During an interview on January 12, 2022, at approximately 2:42 p.m., HM-A confirmed R8's record lacked a completed bed rail assessment and lacked documentation of the risks versus benefits of bed rail use. The licensee's policy on bed rail use was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		