DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 17, 2023

Licensee
Diamond Willow Of Detroit Lake
1558 Randolph Road
Detroit Lakes, MN 56501

RE: Project Number(s) SL25380015

Dear Licensee:

On April 12, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the February 1, 2023, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Electronically Delivered

February 17, 2023

Licensee
Diamond Willow Of Detroit Lake
1558 Randolph Road
Detroit Lakes, MN 56501

RE: Project Number(s) SL25380015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are 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 statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25380	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF DETROIT LAKE	1558 RANDOLPH ROAD DETROIT LAKES, MN 56501

(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) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25380015 On January 30, 2023, through February 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 active residents, all of whom were receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on January 31, 2023, issued for SL25380015, tag identification 2070. On January 31, 2023, at 4:41 p.m., the immediacy of correction order 2070 was removed, however, non-compliance remained at a scope and level of I. An immediate correction order was identified on January 31, 2023, issued for SL25380015, tag identification 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On February 1, 2023, at 9:17 a.m., the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of H.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of	0 250		

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0 250	Continued From page 2 the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 250		

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0 250	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 30, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent director of operations (DO)-L, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	0 250		

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0 250	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing	0 250		

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0 250	Continued From page 5 the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorizing agent DO-L on November 9, 2022. The licensee had an assisted living license reissued on January 1, 2023, with an expiration date of December 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -conducting initial and ongoing resident evaluations and assessments of resident needs -orientation to and implementation of the assisted living bill of rights -infection control practices -medication and treatment management - delegation of tasks by registered nurses or licensed health professionals	0 250		

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0 250	Continued From page 6 As a result of this survey, the following orders were issued 0250, 0480, 0510, 0640, 0700, 0800, 0900, 0910, 1060, 1610, 1620, 1630, 1640, 1690, 1760, 1770, 1790, 1880, 1890, 1910, 1940, 1960, 2070, 2140, 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 480		

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0 480	Continued From page 7 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). In addition, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel (ULP)-D during personal cares for R7. This had the potential to affect all 21 residents, staff, and visitors. 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: PPE - MASKS On January 30, 2023, at 10:00 a.m., upon entrance to the facility the evaluator observed the following signage posted on the wall in the main entrance area: "STOP masking is required at this time." On January 30, 2023, at 11:50 a.m., the evaluator observed ULP-D to conduct a blood glucose check and administer R1's scheduled medications which included insulin. The evaluator observed several times ULP-D's face mask be lower on her face exposing her nose.	0 510		

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0 510	Continued From page 9 On January 31, 2023, at 6:05 a.m., the evaluator observed assisted living coordinator (ALC)-N in the kitchen not wearing a mask. On January 31, 2023, at 6:12 a.m., the evaluator observed ULP-J and ULP-K in the main dining room area and neither ULP were wearing a mask. On January 31, 2023, at 6:15 a.m., the evaluator observed ULP-F assisting R8 from his room to the open living room area and ULP-F was not wearing a mask. On January 31, 2023, at 2:16 p.m., the evaluator observed ULP-D to be seated in the open living room area speaking to an unknown resident who was seated directly beside ULP-D. The evaluator observed ULP-D's mask to be looped around each ear and positioned under her chin exposing her nose and mouth. On February 1, 2023, at 10:52 a.m., assistant director (AD)-G stated the facility followed the Centers for Disease Control and Prevention (CDC) guidelines with regards to PPE usage. AD-G stated she reviewed the county's transmission level weekly and sends this information out to the facility. AD-G stated all staff should be wearing masks and the masks should be applied appropriately as the facility's county transmission level was high. On February 1, 2023, at 11:08 a.m., AD-G provided the county's transmission level and CDC guidance for PPE for the facility based off the following reference: The CDC COVID Data Tracker: COVID:19 Integrated County View (covid.cdc.gov/covid-data-tracker/#county-view).	0 510		

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0 510	Continued From page 10 The Minnesota Department of Health (MDH) Masks: COVID-19 guidelines dated December 14, 2022, noted a mask should cover the nose and mouth completely and fit snugly against your face without gaps. The mask should not be overly tight or restrictive and should feel comfortable to wear. PERSONAL CARES On January 31, 2023, at 7:13 a.m., the evaluator observed ULP-D and ULP-I enter R7's room and don a pair of gloves. ULP-D and ULP-I proceeded to provide incontinence and wound care for R7 who was laying in her bed. ULP-I lowered the covers on R7's bed while ULP-D gathered a new brief and supplies. ULP-D partially removed R7's brief and with ULP-I assisting positioned R7 on to her right side. The evaluator observed R7 had been incontinent of bowel and bladder. ULP-D used gloved hands and several disposable wipes cleaned R7's bottom. ULP-D removed her gloves. ULP-D did not perform hand hygiene after removal of her gloves. ULP-D with assistance from ULP-I placed a new brief under R7 and positioned R7 on to her back. ULP-D donned a new pair of gloves and used several disposable wipes and cleansing spray provided peri-care. ULP-D removed her gloves. ULP-D did not perform hand hygiene after removal of her gloves. With gloved hands ULP-D sprayed wound cleanser on to R7's undressed burn wound located on her left thigh area and wiped the wound with a disposable wipe. ULP-D removed her gloves. ULP-D did not perform hand hygiene after removal of her gloves. ULP-D donned a new pair of gloves, secured R7's brief, and placed a nickel sized amount of Diaper Rash Ointment and Skin Protector on to her gloved hand. ULP-D	0 510		

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	25380	A. BUILDING: _____ B. WING _____	02/01/2023

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0 510	Continued From page 11	0 510		

proceeded to apply the ointment to R7's burn wound on her left thigh. ULP-D removed her gloves. ULP-D did not perform hand hygiene after removal of her gloves. ULP-D and ULP-I put pants on R7 and using a mechanical lift transferred R7 from the bed to a recliner. ULP-I removed her gloves. ULP-I did not perform hand hygiene after removal of her gloves. ULP-I exited R7's room. ULP-D proceeded to put deodorant on R7, finished dressing R7, and fix R7's hair. At 7:34 a.m., ULP-D exited R7's room and went to the kitchen sink and washed her hands.

On January 31, 2023, at 7:36 a.m., directly following the above observation, ULP-D stated she had not washed her hands after each time she had removed her gloves or between providing incontinence care and application of the ointment to R7's wound. ULP-D stated "we aren't supposed to wash our hands in the resident's rooms" but "I guess I could have used hand sanitizer".

On February 1, 2023, at 10:49 a.m., AD-G stated staff should perform hand hygiene each time they remove their gloves and between tasks such as providing incontinence and wound care services.

The licensee's Handwashing policy dated September 4, 2022, noted handwashing would be performed by all employees, as necessary and between tasks to prevent cross-contamination. When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.

The licensee's Gloves policy dated September 4, 2022, noted gloves should be worn whenever there may be direct contact between any

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0 510	Continued From page 12 employee and contaminated objects. The procedure directed to rewash hands after removal of gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all residents, staff, and visitors. 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	0 640		

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0 640	Continued From page 13 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: On January 30, 2023, from 11:20 a.m. through 12:10 p.m., during the facility tour, the evaluator did not observe 911 posted on or near telephones in the commons areas as required. On January 30, 2023, at 12:10 p.m., licensed practical nurse (LPN)-B verified the 911 emergency number were not posted at or near telephones or in the Burlington wing or Soo Line wing. The licensee's Emergency Contacts for Staff policy dated September 5, 2022, indicated emergency numbers would be posted in the office or available on R-task (electronic medical record). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.	0 700		

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0 700	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all 21 residents. 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: On January 30, 2023, at 11:49 a.m., the evaluator observed an open computer tablet sitting on the arm of a recliner in the open living/dining room area. The computer screen displayed several resident's name and private information. There were four visitors seated at a dining room table with a resident and two other residents seated in wheelchairs adjacent to the recliner with the open computer tablet. On January 30, 2023, at 12:00 p.m., the evaluator observed two open computer tablets sitting on top of the medication cart in the open living/dining room area in the Burlington unit. The computer screens displayed resident names and medication information. There was one resident seated in a wheelchair near the medication cart. There were no staff in the immediate area. On January 30, 2023, at 12:16 p.m., licensed	0 700		

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0 700	Continued From page 15 practical nurse (LPN)-B observed the two open computer tablets noted above with the evaluator. LPN-B stated the computer tablets should be covered or turned over when they are not in use, so the screen was not visible. On January 30, 2023, at 3:27 p.m., the evaluator observed two open computer tablets sitting on top of the medication cart in the open living/dining room area in the Soo unit. The computer screens displayed resident information. There was one resident seated on the couch near the medication cart and no staff were in the immediate area. On February 1, 2023, at 10:45 a.m., the evaluator observed one open computer tablet sitting on top of the medication care in the open/dining room area in the Burlington unit. The computer screen displayed resident information. There were three residents seated in the area near the medication cart with no staff in the immediate area. The licensee's Resident Record - Access and Storage policy dated September 5, 2022, noted all information in the resident record is confidential; all staff are responsible to make sure confidentiality is maintained for all resident records and information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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0 800	Continued From page 16 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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, but was not likely to cause 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). Findings include: On a facility tour on January 30, 2023, at approximately 2:00 p.m. and with the Director of Operations (DO)-L, it was observed that the fire doors located in the Link area of the facility were propped in the open position by using furniture to prevent them from closing. Doors propped open by the use of furniture will not be allowed to automatically close and compartmentalize as designed in the event of a fire. These deficient conditions were visually verified by (DO)-L as he accompanied us on the tour.	0 800		

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0 800	Continued From page 17 TIME PERIOD FOR CORRECTION: 7 DAYS	0 800		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility,	0 900		

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0 900	Continued From page 18 a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of three residents (R1) with records reviewed. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, hyperlipidemia (high cholesterol), congested heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), obesity, hypertension (HTN-high blood pressure), memory impairment, and depression. R1's service plan dated July 15, 2022, indicated the resident received services to include medication administration, blood glucose monitoring, oxygen therapy, assistance with bathing, toileting, dressing, grooming, and transferring. On January 30, 2023, at 11:50 a.m., the evaluator	0 900		

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0 900	Continued From page 19 observed unlicensed personnel (ULP)-D conduct a blood glucose check and administer R1's scheduled medications. R1's records lacked a written contract which included the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement In addition, R1's records lacked evidence that the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On February 1, 2023, at 12:06 p.m., licensed assisted living director (LALD)-A stated she did not have a signed assisted living contract for R1. The licensee's Contract Requirements policy dated September 5, 2022, noted an assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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0 910	Continued From page 20	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R7, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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: R7's Resident Lease and Services Agreement (assisted living contract) effective September 1, 2022, was signed by the resident's responsible person on September 1, 2022. R5's Resident Lease and Services Agreement	0 910		

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0 910	Continued From page 21 effective November 22, 2022, was signed by the resident's responsible person on November 22, 2022. R7 and R5's assisted living contracts lacked the following required content: - the licensee's HFID number (provider identification number) On February 1, 2023, at 11:25 a.m., director of operations (DO)-L stated the contract was the current contract used by the licensee for all residents. DO-L stated the license number information listed on the contract was incorrect. The licensee's Contract Requirements policy dated September 5, 2022, indicated the contract would include the license number of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider;	01060		

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01060	Continued From page 22 (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative: and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R6).	01060		

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01060	Continued From page 23 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Discharged Resident/Client Roster dated January 30, 2023, indicated R6 was admitted on October 11, 2021, and was discharged on November 18, 2022, to another facility. R6's record lacked a service plan. R6's Assessment dated July 12, 2022, indicated R6 received medication administration services and assistance with bathing, dressing, and housekeeping. R6's Resident Notes - Nurse included the following: - July 27, 2022, at 7:47 p.m., R6 was at home with family and had a fall which was witnessed by the grandson. R6 was brought to a nearby hospital by the daughter. R6 will require surgery to repair her ankle. - October 21, 2022, at 9:59 p.m., R6 has been hospitalized from July 27, 2022, through August 22, 2022, for repair of a fractured right fibula (smaller bone between the knee and the ankle). Following hospitalization R6 was admitted to a nursing home. - November 1, 2022, at 11:16 a.m., R6 will not be returning to the facility today. R6's Discharge - Transfer Summary dated	01060		

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(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) COMPLETE DATE
01060	Continued From page 24 December 14, 2022, noted R6 was discharged on November 18, 2022, to a nursing home following a fall and surgical repair of a facture. R6's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R6's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On January 31, 2023, at 9:06 a.m., licensed assisted living director (LALD)-A stated R6 had been hospitalized on July 27, 2022. Following R6's hospitalization she had went to the nursing home and did not return to the facility and was discharged on November 18, 2022. LALD-A stated the emergency relocation written notice had not been completed for R6 nor had the OOLTC been notified as required. The licensee's Emergency Relocation policy dated September 5, 2022, indicated the facility would provide a written notice to the resident, legal representative, and designated	01060		

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01060	Continued From page 25 representative with the reason for the relocation, name and contact information for the location, contact information for the OOLTC, if known the approximate date range within the resident was expected to return to the facility, or a statement that a return date was not currently known, and a statement if the facility refuses to provide services after relocation, the resident has the right to appeal. In addition, the facility would deliver the notification to the OOLTC if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.	01610		

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01610	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a physical and cognitive assessment of a prospective resident on or before move-in for one of one resident (R5). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's diagnoses included sacral fracture, diabetes, and depression. R5's record did not include a service plan. On January 31, 2023, at 7:32 a.m., the evaluator observed unlicensed personnel (ULP)-M administer R5's scheduled morning medications. R5's record contained an admission assessment dated November 28, 2022, six (6) days after moving into the facility. On February 1, 2023, at 11:01 a.m., licensed assisted living director (LALD)-A stated R5's initial assessment was completed six (6) days after admission. LALD-A stated the initial assessment should be completed no later than the resident's admission date.	01610		

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01610	Continued From page 27 The licensee's Nursing Assessments, Delegated Nursing Services and Supervision Policy and Procedures dated September 4, 2022, indicated the RN will complete the initial assessment within five (5) days after initiating of Comprehensive home care services and prior to the initiation of any delegated nursing services by ULP's. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

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01620	Continued From page 28 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment for one of one resident (R7) with a change of condition; and failed to ensure the registered nurse (RN) conducted a comprehensive 90-day reassessment for one of two residents (R1). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CHANGE OF CONDITION REASSESSMENT R7's diagnoses included glioma of brain (tumor), seizure disorder, and urinary frequency. R7's record lacked a service plan. R7's last assessment was completed on December 24, 2022, by RN-C. This assessment indicated R7 received services to include medication management, laundry, housekeeping, and assistance with bathing, dressing, grooming, and transferring. On January 31, 2023, at 7:13 a.m., the evaluator observed unlicensed personnel (ULP)-D provide incontinence care and wound care to R7's burn	01620		

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01620	Continued From page 29	01620		

located on her inner left thigh area. At 7:51 a.m., ULP-D stated R7 had spilled some hot coffee in her lap.

R7's Other Injury (incident report) dated January 20, 2023, indicated R7 had been seated in her recliner with her husband in attendance. R7's husband heated her coffee up in the microwave and handed it to her. R7 promptly spilled the coffee in her lap. R7's clothes were removed immediately. Licensed practical nurse (LPN)-B indicated in the injury report R7 sustained a scalded area on her left inner upper thigh which measured 3x4 inches; and at the top of the 3x4 area there was a 1x2 inch blister with the top of the blister sheared off.

R7's Resident Notes - Nurse included the following:
- January 20, 2023, at 1:40 p.m., LPN-B noted the nurse practitioner (NP) had been notified and the licensee received an order to apply Mepilex (an absorbent foam dressing) to the open area and change the dressing every three (3) days. The NP will make rounds on January 23, 2023, to assess the area.
- January 20, 2023, at 1:40 p.m., LPN-B noted the reddened scalded area was receding and improving in both color and size. The area was cleansed with wound cleanser and Mepilex applied. R7 stated it feels better and only hurts when cleaned.
- January 23, 2023, at 1:38 p.m., R7 seen by NP. Orders to continue for Mepilex dressing to affected area, change every three days, call NP with concerns.
- January 26, 2023, at 6:30 a.m., wound care completed, and new dressing applied.
- January 31, 2023, at 7:52 p.m., (late entry for January 23, 2023, written by RN-C) noted RN-C

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01620	Continued From page 30 had assessed R7's burn area measuring 3x4 inches. Clear drainage was noted on dressing with redness. Blister was no longer apparent. R7's wound was cleansed, and new dressing applied. R7's prescriber notes, dated January 23, 2023, indicated R7 was seen for concerns about a burn on her skin. NP documented, "Today there continues to be an open area, however it looks like it is healing nicely. There is no surrounding redness. No drainage. She [R7] stated that it hurts only if it is rubbed against her clothes. Continue with Mepilex dressing, change every 3 days and as needed." R7's prescriber orders dated January 23, 2023, included an order to continue with Mepilex dressing change every three days and as needed to left thigh, update prescriber with concerns. R7's record lacked a change of condition reassessment following the incident which R7 sustained a burn on her left upper thigh. On February 1, 2023, at 11:05 a.m., RN-C stated resident reassessments should be completed with any changes of a resident's condition. RN-C stated a change of condition assessment had not been completed after R7 sustained a burn and one should have been completed by the RN. 90-DAY REASSESSMENTS R1's diagnoses included diabetes, hyperlipidemia (high cholesterol), congested heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), obesity, hypertension	01620		

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01620	Continued From page 31 (HTN-high blood pressure), memory impairment, and depression. R1's service plan dated July 15, 2022, indicated the resident received services to include medication administration, blood glucose monitoring, oxygen therapy, assistance with bathing, toileting, dressing, grooming, and transferring. On January 30, 2023, at 11:50 a.m., the evaluator observed ULP-D conduct a blood glucose check and administer R1's scheduled medications. R1's last two comprehensive 90-day reassessments dated August 3, 2022, and November 6, 2022, respectively were completed by licensed practical nurse (LPN)-O. On February 1, 2023, at 11:18 a.m., RN-C stated all comprehensive assessments and reassessments should be completed by a RN. RN-C stated R1's 90-day assessments noted above were completed prior to her employment with the facility. The licensee's Nursing Assessments, Delegated Nursing Services and Supervision policy dated September 4, 2022, noted the RN would reassess the resident any time the resident returned from a hospital or nursing home stay, had a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications. The RN will re-assess each resident on an on-going basis. The RN will determine the frequency of monitoring and reassessments based on the resident's needs, with the frequency being no later than 14 days after the initial assessment and then not to	01620		

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01620	Continued From page 32 exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to initiate a temporary service plan for one of one resident (R11). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R11 was admitted on January 24, 2023, and received services under the licensee's assisted living with dementia care license. R11's diagnoses included dementia,	01630		

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01630	Continued From page 33 osteoarthritis, and bladder cancer. R11's assessment dated January 25, 2023, indicated R11 received services to include medication management, laundry, housekeeping, and assistance with bathing, dressing, grooming, toileting, and transferring. On February 1, 2023, at 11:02 a.m., licensed assisted living director (LALD)-A stated each resident's service plan was usually completed upon admission and then modified at 14 days if needed. LALD-A stated she was unable to find a temporary service plan for R11. Assistant director (AD)-G stated the registered nurse was responsible for the development of the service plan after a resident assessment. The licensee's Service Plans policy dated September 4, 2022, indicated the licensee will provide services to clients after the registered nurse completes an assessment and a service plan is developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01630		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640		

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01640	Continued From page 34 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided for two of four residents (R7, R5). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R7 R7 was admitted on September 1, 2022, and received services under the licensee's assisted	01640		

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01640	Continued From page 35 living with dementia care license. R7's diagnoses included glioma of brain (tumor), seizure disorder, and urinary frequency. R7's assessment dated December 24, 2022, indicated R7 received services to include medication management, laundry, housekeeping, and assistance with bathing, dressing, grooming, and transferring. On January 31, 2023, at 7:13 a.m., the evaluator observed unlicensed personnel (ULP)-D and ULP-I provide incontinence care and transfer R7 with a mechanical lift. At 7:40 a.m., the evaluator observed ULP-D administer R7's scheduled morning medications. R5 R5 was admitted on November 22, 2022, and received services under the licensee's assisted living with dementia care license. R5's diagnoses included sacral fracture, diabetes, and depression. R5's assessment dated December 10, 2022, indicated R5 received services to include medication management, laundry, housekeeping, and assistance with bathing, and dressing. On January 31, 2023, at 7:32 a.m., the evaluator observed ULP-M administer R5's scheduled morning medications. R7 and R5's record lacked a service plan. On February 1, 2023, at 11:02 a.m., licensed assisted living director (LALD)-A stated each resident's service plan was usually completed	01640		

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01640	Continued From page 36 and signed at the time of admission. Assistant director (AD)-G stated the registered nurse was responsible for the development of the service plan and the service plans should be reviewed every 90 days when the assessments are conducted. LALD-A stated she was unable to find a service plan for R5 and R7. The licensee's Service Plans policy dated September 4, 2022, indicated the licensee would finalize a written service plan within 14 days after the initiation of services and would include a signature by the client or the client's representative in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are	01690		

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01690	Continued From page 37 administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances were maintained for one of one resident (R2). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On January 30, 2023, at 10:30 a.m., during the entrance conference, licensed practical nurse (LPN)-B stated all narcotic medication were double locked and counted by two staff members at the end/start of each shift. The staff members	01690		

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(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) COMPLETE DATE
01690	Continued From page 38 documented this reconciliation in the narcotic log book (a bound paper book which documents the removal and addition of the identified controlled substance). On January 30, 2023, at 12:22 p.m., the evaluator toured the facility with LPN-B, including a review of the locked narcotic box in the Soo Line nurse office. The narcotic box contained the following medication: -Ativan 0.5 milligram (mg) tablet in a bubble pack card containing 14 tablets for R2. On January 30, 2023, at 12:45 p.m., licensed assisted living director (LALD)-A and LPN-B were unable to account for R2's medication noted above in the narcotic log book LPN-B stated the Ativan entry must have been missed in the narcotic log book when the medication was received from the pharmacy. LPN-B stated the normal practice was to document the narcotics in the overflow narcotic log book when they are received or taken out. The licensee's Narcotic Log policy dated September 4, 2022, indicated to ensure that all narcotics are properly accounted for, upon receiving a new supply of narcotics it will be recorded on an individual page in the narcotic logbook and will be counted at the start of the day shift and during the evening shift. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 39 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of five residents (R8). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R8's diagnoses included dementia, restless legs syndrome, and gastroesophageal reflux disease (GERD). R8's service plan dated June 28, 2022, included medication management services.	01760		

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01760	Continued From page 40 R8's assessment dated May 5, 2022, indicated unlicensed personnel (ULP) would administer all medications as ordered by the prescriber. R8's prescriber orders dated May 31, 2022, included pantoprazole 40 milligram (mg) tablet take one (1) tablet by mouth every morning and do not crush. On January 31, 2023, at 7:15 a.m., the evaluator observed unlicensed personnel ULP-M prepare R8's morning medications including pantoprazole (used to treat acid reflux) 40 mg tablet with a label that indicated DO NOT CRUSH. ULP-M confirmed all medications in the electronic medication administration record (EMAR) and then placed the medications into a small plastic sleeve. ULP-M crushed all of R8's morning medications, placed them in yogurt and administered to R8. ULP-M stated they (ULP's) crush all of R8's medications and she has not been told to do it any different. ULP-M was not able to locate instructions of pantoprazole not to be crushed in the EMAR. On February 1, 2023, at 10:57 a.m., licensed assisted living director (LALD)-A stated any medication that should be crushed would be indicated on the prescriber's order and then transcribed into the EMAR. The manufacturer's instructions for pantoprazole dated July 2017, indicated pantoprazole should be swallowed whole and should not be crushed. The licensee's Medication Administration and Crushing Meds (medications) policy dated September 4, 2022, indicated when staff crush medications, they must only give medications that	01760		

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01760	Continued From page 41 are indicated to be crushed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R10). 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 the residents). The findings include: During the entrance conference on January 30, 2023, at 10:36 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services.	01770		

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01770	Continued From page 42 R10's diagnoses included dementia, hypertension (HTN-high blood pressure), congestive heart failure (CHF), and atrial fibrillation (irregular often fast heart rate). R10's service plan dated June 28, 2022, indicated R10 received medication management services. R10's prescriber orders dated January 19, 2023, included an order for morphine concentrate (medication to treat severe pain) 100 milligrams/5 milliliters (mg/ml) give 2 mg (0.1 ml) by sublingual (under the tongue) every 8 hours. On January 31, 2023, at 6:20 a.m., the evaluator observed unlicensed personnel (ULP)-F and assisted living coordinator (ALC)-N complete the narcotic count on the medication cart in the Soo Line wing. Observed in the medication cart was a clear baggie with three (3) prefilled syringes labeled with R10's name and identified as morphine 2mg/0.1 ml. ULP-F stated the syringes had been set up by licensed practical nurse (LPN)-B or Hospice. R10's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. On January 31, 2023, at 11:40 a.m., LALD-A stated LPN-B would setup R10's morphine syringes and the medication setup was not documented as required. LALD-A stated medication set ups are not documented. The licensee's Medication Administration -	01770		

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01770	Continued From page 43 Weekly Dosage Box Setup policy dated September 4, 2022, indicated for medications that cannot be setup in the dosage box (topical or liquid) will be recorded on the medication administration record (MAR) to include medication name, quantity of dose, times to be administered, and route of administration. When the licensed nursed has completed setting up the medications the setup is documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed	01790		

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01790	Continued From page 44 staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	01790		

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01790	Continued From page 45 Based on observation, interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-I) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on January 30, 2023, at 10:36 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services and when the licensed nurse was not available the ULP could prepare and send medications with a resident. ULP-I was hired on June 28, 2022, to provide direct care services for the licensee's residents which included medication administration. On January 31, 2023, at 7:02 a.m., the evaluator observed ULP-I administer R12's scheduled morning medication. ULP-I's employee record lacked evidence to indicate she had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On February 1, 2023, at 12:30 p.m., registered	01790		

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01790	Continued From page 46 nurse (RN)-C stated ULP-I had not been trained or deemed competent to prepare and give medications to residents for an unplanned time away. The licensee's Procedure for Planned and Unplanned Time Away policy dated September 4, 2022, noted for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested ULP may give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed five days (120 hours). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions. 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	01880		

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01880	Continued From page 47 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 the residents). The findings include: On January 30, 2023, at 11:20 a.m., the evaluator toured the facility with licensed practical nurse (LPN)-B, including a review of the medication refrigerator in the locked storage room on the Burlington wing. The following was observed: On January 30, 2023, at 11:22 a.m., LPN-B opened the medication refrigerator on the Burlington wing and stated the current temperature was 41 degrees Fahrenheit (F). LPN-B stated there was not a refrigerator log to mark down the temperature daily and would be expected of staff to check the medication refrigerator temperature daily. The refrigerator contained the following medications: -one opened bottle of lorazepam 0.125 milliliters (mL) for R13 -four unopened Trulicity 4.5milligrams (mg) pens for R1 The refrigerator log was reviewed with LPN-B and she confirmed the temperature of the medication refrigerator had been recorded zero (0) times out of 61 daily opportunities from December 1, 2022, through January 30, 2023. LPN-B stated it would be expected of staff to document the medication refrigerator temperature daily. The manufacturer's instructions for lorazepam dated August 2022, indicated to store the liquid	01880		

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01880	Continued From page 48 medication in the refrigerator (36-46 degrees F). The manufacturer's instructions for Trulicity dated January 2017, indicated before opening store the pen in the refrigerator (36-46 degrees F). Do not allow Trulicity to freeze. The licensee's Storage of Medications policy dated November 23, 2016, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for five of five residents (R3, R4, R7, R9, R1). In addition, the licensee failed to monitor for expired medications in the licensee's stock medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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01890	Continued From page 49 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 the residents). The findings include: On January 30, 2023, at 11:20 a.m., the evaluator toured the facility with licensed practical nurse (LPN)-B including a review of the two locked medication carts. The following was observed and confirmed with LPN-B and unlicensed personnel (ULP)-F: DATING TIME SENSATIVE MEDICATIONS -R3's opened Spiriva 2.5 micrograms (mcg)/actuation (ACT) did not have a label which indicated when the inhaler was opened and when the inhaler would expire -R4's opened Lantus insulin 100 units/milliliters (mL) pen (a multiple dose pen shaped injector device for insulin administration) did not have a label which indicated the date the pen had been opened and when the pen would expire -R7's opened Ventolin HFA 90 mcg inhaler did not have a label which indicated when the inhaler was open and when it would expire On January 30, 2023, at 8:35 a.m., the evaluator observed ULP-M administer R9's scheduled Basaglar 12 units of insulin. R9's Basaglar 100 units/mL pen did not have a label which indicated the date the insulin pen had been opened and when the pen would expire. ULP-M stated the insulin pen should be dated when opened. On January 30, 2023, at 11:50 a.m., the evaluator observed ULP-D administer R1's scheduled	01890		

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01890	Continued From page 50 Novolog 10 units of insulin. R1's Novolog 100 units/mL and Lantus 100 units/mL insulin pens did not have a label which indicated the date the insulin pens had been opened and when the pens would expire. ULP-D stated the insulin pens should be dated when opened. On January 30, 2023, at 12:57 p.m., LPN-B stated insulin pens, eye drops, and inhalers should be dated when opened. The manufacturer's instructions for Spiriva inhaler dated November 2021, directed to discard the inhaler after 3 months after first use. The manufacturer's instructions for Lantus insulin pens dated May 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Ventolin HFA inhaler dated December 2014, directed to discard the inhaler twelve months after removing from the foil pouch. The manufacturer's instructions for Basaglar insulin pens dated July 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Novolog insulin pens dated October 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. EXPIRED MEDICATIONS -stock supply of twelve Bisacodyl suppositories expired February 2022 -stock supply Senna Plus stool softener bottle expired November 2022	01890		

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01890	Continued From page 51 On January 30, 2023, at 12:57 p.m., LPN-B stated it would be expected of ULP's to check medication expiration dates before administering to residents. The licensee's Medication Disposal policy dated September 4, 2022, indicated any expired medication managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of pharmacy and the labels from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 52 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R6) upon discharge. 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, 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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 30, 2023, at 10:28 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R6's diagnoses included rheumatoid arthritis, hypertension (HTN-high blood pressure), cognitive impairment, atrial fibrillation (irregular often fast heartrate), and diabetes. R6's record lacked a service plan. R6's Assessment dated July 12, 2022, indicated R6 received medication administration services. R6's Resident Notes - Nurse included the following:	01910		

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	25380	A. BUILDING: _____ B. WING _____	02/01/2023

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01910	Continued From page 53 - July 27, 2022, at 7:47 p.m., R6 was at home with family and had a fall which was witnessed by the grandson. R6 was brought to a nearby hospital by the daughter. R6 will require surgery to repair her ankle. - October 21, 2022, at 9:59 p.m., R6 has been hospitalized from July 27, 2022, through August 22, 2022, for repair of a fractured right fibula (smaller bone between the knee and the ankle). Following hospitalization R6 was admitted to a nursing home. R6's Medication Administration Record (MAR) for July 2022, indicated R6 received the following medications: - acetaminophen 650 milligrams (mg) daily - Amaryl (antidiabetic medication) 4 mg daily - Eliquis (blood thinner) 5 mg twice daily - diclofenac 1% (topical pain reliever) applied four times daily - digoxin (medication to treat irregular heart rhythm) 0.125 mg every 48 hours - folic acid (vitamin) 1 mg daily - Hiprex (medication to treat recurring urinary tract infections) 1 gram twice daily - Januvia (antidiabetic medication) 100 mg daily - methotrexate (immunosuppressant) 20 mg once weekly - Lopressor (antihypertensive) 100 mg twice daily - nystatin powder (antifungal) three times daily - potassium chloride (mineral supplement) 20 milliequivalent (mEq) daily - prednisone (corticosteroid) 4 mg daily - vitamin D3 50 microgram (mcg) daily - ferrous sulfate (iron supplement) 325 mg daily - pravastatin (medication to lower cholesterol) 40 mg at bedtime - Zoloft (antidepressant) 50 mg at bedtime R6's record lacked provider orders.	01910		

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01910	Continued From page 54 R6's Discharge - Transfer Summary dated December 14, 2022, noted R6 was discharged on November 18, 2022, to a nursing home following a fall and surgical repair of a facture. R6's record did not include documentation for the disposition of the above noted medications to include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On January 31, 2023, at 9:08 a.m., LALD-A stated R6's record lacked the required content for the disposition of medications noted above. The licensee's Discharge Assessments policy dated September 5, 2022, noted upon a client's discharge the disposition of the client's medications, including the medication name, strength, prescription number, quantity, to whom the medications were given or who disposed of them; and the names of staff or others involved in the disposition will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 55 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1, R7) who had treatments managed by the facility. 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	01940		

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01940	Continued From page 56 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on January 30, 2023, at 10:23 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents at the facility. R1 R1's diagnoses included diabetes, hyperlipidemia (high cholesterol), congested heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), obesity, hypertension (HTN-high blood pressure), memory impairment, and depression. R1's service plan dated July 15, 2022, indicated the resident received services to include oxygen therapy. R1's prescriber orders dated December 2, 2022, included an order for oxygen therapy 2.5 liters per nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) continuously. On January 30, 2023, at 11:50 a.m., the evaluator observed R1 laying in her bed. R1 was receiving oxygen therapy at 2.5 liters via an oxygen concentrator.	01940		

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01940	Continued From page 57 R1's record did not include evidence of an individualized treatment or therapy management plan for R1's oxygen therapy which included procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services. On February 1, 2023, at 12:07 p.m., LALD-A stated R1's treatment and therapy management plan for oxygen therapy was incomplete as it did not include the above noted required content. R7 R7's diagnoses included glioma of brain (tumor), seizure disorder, and urinary frequency. R7's record lacked a service plan. R7's prescriber orders dated January 23, 2023, included an order to continue with Mepilex (an absorbent foam dressing) change every three days and as needed to left thigh, update prescriber with concerns. On January 31, 2023, at 7:13 a.m., the evaluator observed unlicensed personnel (ULP)-D provide wound care to R7's burn located on her inner left thigh area. ULP-D with gloved hands sprayed wound cleanser on R7's burn wound and wiped the wound with a disposable wipe. ULP-D removed her gloves. ULP-D did not perform hand hygiene after removal of her gloves. ULP-D donned a new pair of gloves, secured R7's brief, and placed a nickel sized amount of Diaper Rash Ointment and Skin Protector on to her gloved hand. ULP-D proceeded to apply the ointment to R7's burn wound on her left thigh. R7's record did not include evidence of an	01940		

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01940	Continued From page 58 individualized treatment or therapy management plan for R7's wound care which included: - a written statement on the service plan of the treatment or therapy services that will be provided to the resident - identification of treatment or therapy tasks that will be delegated to ULP, and - verification that all treatment and therapy was administered as prescribed On February 1, 2023, at 11:16 a.m., LALD-A stated a treatment plan for R7's wound care had not been developed as required. The licensee's Development of Treatment or Therapy Management Plans dated September 4, 2022, noted the registered nurse (RN) was responsible for the development of the treatment and therapies plans. The service plan will be updated by the licensed nurse to reflect the order of the prescriber, the directions for treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must	01960		

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01960	Continued From page 59 document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one resident's (R7) dressing change was provided as directed by the prescriber. 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, 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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7's diagnoses included glioma of brain (tumor), seizure disorder, and urinary frequency. R7's record lacked a service plan. R7's prescriber orders dated January 23, 2023, included an order to continue with Mepilex (an absorbent foam dressing) change every three days and as needed to left thigh, update prescriber with concerns. R7's January 23, 2023, through January 31, 2023, medication administration record (MAR) directed for Mepilex dressing to be applied every three days and as needed by the nurse. R7's Resident Notes - Nurse dated January 20,	01960		

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01960	Continued From page 60 2023, through January 26, 2023, indicated the nurse had completed the dressing change on R7's burn wound every three days as ordered. On January 31, 2023, at 7:13 a.m., the evaluator observed unlicensed personnel (ULP)-D provide wound care to R7's burn located on her inner left thigh area. ULP-D with gloved hands sprayed wound cleanser on R7's burn wound and wiped the wound with a disposable wipe. ULP-D removed her gloves. ULP-D did not perform hand hygiene after removal of her gloves. ULP-D donned a new pair of gloves, secured R7's brief, and placed a nickel sized amount of Diaper Rash Ointment and Skin Protector on to her gloved hand. ULP-D proceeded to apply the ointment to R7's burn wound on her left thigh. ULP-D did not apply a dressing to R7's wound. On February 1, 2023, at 11:15 a.m., registered nurse (RN)-C stated prescriber orders for R7's wound care had not been followed as the licensee did not have orders to administer Diaper Rash Ointment and Skin Protector on R7's burn wound. RN-C stated the nurse should be completing R7's wound care and not the ULP. The licensee's Treatment or Therapy Orders policy dated September 4, 2022. noted treatment and therapies will be performed as prescribed by authorizing provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement	02070		

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02070	Continued From page 61 An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured dementia care units. This had the potential to affect all residents residing in the facility. 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). This practice resulted in an immediate order on January 31, 2023, at approximately 12:40 p.m. The findings include: The licensee failed to ensure one or more staff were always available during all shifts in each of the two separate secured dementia care units.	02070		

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02070	Continued From page 62 The licensee held an Assisted Living with Dementia Care license with a capacity of 30 residents and had a current census of 21 residents. On page two (2) of the Application for Assisted Living License signed by director of operations (DO)-L on November 9, 2022, listed two separate assisted living buildings with separate addresses covered under this assisted living with dementia care license. During the entrance conference on January 30, 2023, at 10:44 a.m., licensed practical nurse (LPN)-B stated the facility's staffing schedule included four staff on the day shift (6:30 a.m. to 2:30 p.m.), four staff on duty on the evening shift (2:30 p.m. to 10:30 p.m.) and four staff on duty on the night shift (10:30 p.m. to 6:30 a.m.). Then Monday through Friday both LPN-B and registered nurse (RN)-C work eight hours on the day shift. The two fire doors that enter from each secure unit into the middle community room are left open. LPN-B stated they are "rarely shut". In addition, LPN-B stated some residents required a mechanical lift (a mechanical device used to assist with transferring). The physical layout of the facility consists of two units (Soo and Burlington) connected by a link (large community room). Each unit consists of a hallway, which measured 139 feet in length. The community room measured 68 feet in length and was separated by fire exit doors, which required a key code to open. The Burlington unit had 10 resident rooms, occupied by nine residents, three of which required a two-person mechanical lift transfer. The Soo unit also had 10 resident rooms, occupied by 13 residents. The facility's Uniform Disclosure of Services	02070		

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02070	Continued From page 63	02070		

(UDALSA) dated November 30, 2022, indicated the number of direct care staff typically scheduled per shift was six staff on the day shift; six staff on the evening shift; and three staff on the night shift.

The facility's undated Staffing Pattern based on Number of Residents indicated with a census of 21 residents the night shift (10:30 p.m. to 6:30 a.m.) should be covered with three direct care staff (with an asterisk indicating the night float position was added due to State Survey).

On January 30, 2023, from 10:00 a.m. until 3:59 p.m., the evaluator observed both the Soo and Burlington units key code access doors to be open. At 3:59 p.m., the evaluator observed the DO-L to remove the piano bench from in front of the Soo unit door and close the door.

On January 30, 2023, at 12:37 p.m., the evaluator observed unlicensed personnel (ULP)-D and ULP-E assist R1 transfer from the bed to the recliner with the use of a mechanical lift. ULP-D stated they always use two staff when transferring residents with a mechanical lift.

On January 31, 2023, from 6:05 a.m. until 6:11 a.m., the evaluator observed the Soo unit door was propped open with a piano bench.

On January 31, 2023, at 7:07 a.m., ULP-F stated that most overnights there were only two ULP staffed for the whole facility and doors going into the community room were always propped open.

On January 31, 2023, at approximately 9:05 a.m., the evaluator asked RN-C for the facility's staffing schedules for the last couple of months. The evaluator reviewed the staffing schedules from

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02070	Continued From page 64 November 29, 2022, through January 25, 2023. Out of the 42 daily staffing schedules provided [15 daily staff schedules were missing] one of the night shifts (December 24, 2022) had one ULP scheduled for the night shift (10:30 p.m. - 6:30 a.m.); and 32 out of the remaining 41 daily staffing schedules had two ULP staff scheduled for the night shift. On January 31, 2023, at 10:27 a.m., RN-C stated she was involved with developing the schedule with the housing coordinators. RN-C stated every night shift has two staff scheduled to cover the night shift with the goal to have three staff scheduled. RN-C stated the key code access doors from the Soo unit and Burlington unit into the community room are usually left open. RN-C stated there are times when only two staff are working and one staff member goes over to the other unit to assist with a resident, leaving their assigned unit unattended. The licensee's LIKO Sit-to stand-Lift policy dated September 4, 2022, indicated two staff were required to operate LIKO Sabina lift at all times unless the registered nurse (RN) had approved the resident was safe on lift with one staff. The policy further directed one staff could get the resident ready and attach the sling (if the care plan indicated) but there must be two staff when the machine is in operations at all times. The licensee's Hoyer Lift policy dated September 4, 2022, indicated two staff were needed to be present when assisting a resident with transferring. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02070		

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02070	Continued From page 65 Immediacy is removed as confirmed by evaluation supervisor on January 31, 2023, at 4:41 p.m., however, non-compliance remains at a scope and level of three, widespread (I).	02070		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia, had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. 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, but was not likely to cause serious injury, impairment, or death), and is 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).	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25380	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF DETROIT LAKE	1558 RANDOLPH ROAD DETROIT LAKES, MN 56501

(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) COMPLETE DATE
02140	Continued From page 66 The findings include: The facility was licensed as an assisted living facility with dementia care. During the entrance conference on January 30, 2023, at 10:15 a.m., licensed assisted living director (LALD)-A stated registered nurse (RN)-C oversaw the dementia care training for staff. RN-C's employee record indicated she had completed EduCare's (on-line training curriculum) Dementia series modules one through four. RN-C's employee record lacked evidence of successful completion of EduCare's five-part Dementia series, approved by the Minnesota Department of Health (MDH) commissioner, for skills competency or knowledge test to be the person in charge of overseeing staff training for dementia care. On February 1, 2023, at 10:58 a.m., RN-C stated she did not have a training certificate to verify knowledge and demonstrate competency related to dementia care. RN-C stated she completed on-line training courses that were assigned to her by the licensee. The licensee's ALDC (assisted living dementia care) Additional Dementia Staff Training policy dated September 5, 2022, indicated persons conducting dementia training will be qualified to train in the care of individuals with dementia. Qualifications will include two years or work experience related to Alzheimer's disease or other dementias, or in other health care, gerontology, or another related field, and has completed and passed training approved by MDH.	02140		

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02140	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02310 SS=H	144G.91 Subd. 4 (a) 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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of four residents (R7, R11) with bedrails. In addition, the licensee failed to ensure safe storage of oxygen. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). This resulted in an immediate correction order on January 31, 2023, at approximately 4:40 p.m. The findings include:	02310		

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02310	Continued From page 68 BEDRAILS R7 R7's diagnoses included glioma of brain (tumor), seizure disorder, and urinary frequency. On January 31, 2023, at 7:13 a.m., the evaluator observed R7 laying in her bed. R7's hospital bed had bilateral upper bedrails in the upright position. R7 does not have a signed service plan. R7's assessment dated December 24, 2022, indicated the resident was totally dependent on staff for bathing, dressing, and grooming. R7 needed assistance of two staff with positioning and bed mobility due to right sided weakness and hemiparesis (partial paralysis on one side) and required a two person transfer with a mechanical lift. R7 had a "grab bar on left side of bed" which was used to assist with maintaining and improving independence with bed mobility, positioning/repositioning, and safety per resident request. R7's bedrail was "appropriate based on needs and assessment" and "all spacing between the bedrail and mattress are appropriate". In addition, the resident's legal guardian had been informed about the risks and benefits of having a bedrail. R7's Bed Safety Assessment dated December 24, 2022, indicated "grab bar installed to left side of bed - no siderail (bedrail)". The rational for the bedrail was a request from the family for fall prevention, aid in turning and repositioning. The bed safety zone assessment was identified as not applicable. R7's record lacked a comprehensive assessment on the use of an assistive device to include actual	02310		

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	25380	A. BUILDING: _____ B. WING _____	02/01/2023

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02310	Continued From page 69	02310		

measurements of the entrapment zones and information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.

On January 31, 2023, at 2:50 p.m., licensed assisted living director (LALD)-A stated the actual measurements of the zones of entrapment were not documented in R7's record and they should have been.

R11
R11's diagnoses included dementia, osteoarthritis, and hypertension

R11 does not have a signed service plan.

R11's assessment January 25, 2023, indicated the resident needed significant assistance with bathing, dressing and grooming. R11 needed total dependence for bed mobility, significant assistance for transfers and does not walk. R11 had a hospital style electric bed with upper ¼ bedrails used for assistance with mobility, transfers and positioning. R11's bedrails indicated they are appropriate based upon assessed need and education has been provided to the resident or resident's responsible party in regard to the risks and benefits of the bed rails.

R11's undated Bed Safety Assessment indicated R11 had upper ¼ bed rails on his hospital style bed to aid in transfers, turning and repositioning per resident family's request.

R11's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and information related to interventions implemented by the licensee to mitigate the

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02310	Continued From page 70 resident's risk for safety pertaining to the use of the device. On January 31, 2023, at 3:34 p.m., LALD-A stated the actual measurements of the zones of entrapment were not documented in R11's record and they should have been. On January 31, 2023, at 4:27 p.m., RN-C measured R7's bedrail with evaluator present. The bedrail measured 2.5 inches tall by 9.5 inches wide at the largest open area. RN-C placed pressure on the R7's left bedrail and stated it was "a bit wobbly". At 4:31 p.m., RN-C measured R11's bedrail with evaluator present. The bedrail measured 16 inches tall by 4 inches wide at the largest open area and was securely fastened to the bed. The licensee's Nursing Assessments, Delegated Nursing Services and Supervision policy dated September 4, 2022, noted a bedrail assessment would be completed at the time of admission and every 90 days when a bedrail was in use. Education on bedrail safety will be provided to the resident/resident family if indicated. Registered nurse (RN) will provide options and alternatives for reducing fall or positioning self to the resident/resident family. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "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	02310		

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	25380	A. BUILDING: _____ B. WING _____	02/01/2023

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02310	Continued From page 71 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail	02310		

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02310	Continued From page 72 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. OXYGEN STORAGE On January 30, 2023, at 11:50 a.m., the evaluator observed unlicensed personnel (ULP)-D enter R1's room and administer R1's scheduled medications. The evaluator observed in R1's room 17 oxygen cylinders. Fourteen of these oxygen cylinders were stored in either a heavy cardboard or metal holder on the floor against the wall and one oxygen cylinder was stored in a holder on the back of R1's wheelchair. Two (2) of the tall oxygen cylinders were positioned directly on the floor upright and against the wall. These two oxygen cylinders were not securely stored in a holder or stand. On January 30, 2023, at 12:13 p.m., licensed practical nurse (LPN)-B stated all oxygen cylinders should be stored upright and placed in a holder or stand. The licensee's Cylinder (Portable) Oxygen policy dated September 4, 2022, noted oxygen cylinders should be stored in a metal rack. Do not store oxygen cylinders in a freestanding, upright position. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over.	02310		

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02310	Continued From page 73 No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor on February 1, 2023, at 9:17 a.m., however, non-compliance remains at a scope and level of three, pattern (H).	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64495
St Paul, MN 55164-0495
651-201-4500

Type: Full
Date: *01/30/23*
Time: 11:11:49
Report: 1034231017

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Detroit Lake
1558 Randolph Road
Detroit Lakes, MN56501
Becker County, 03

Establishment Info:
ID #: 0037600
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188460825
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

BREAD DATED 1/25, 1/25, AND 1/27 ALL THROWN AWAY ON SITE.

Corrected on Site

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

COMPLETELY COOK EGGS WHEN SERVING OR SERVE PASTEURIZED EGGS.

Comply By: 01/30/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

WITNESSED EMPLOYEE USE HANDWASHNG SINK TO WASH OUT A MEASURING CUP. ONLY USE HANDWASHING SINK TO WASH HANDS.

Comply By: 01/30/23

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

LISA AND ANGELA WERE TAKING A FOOD SAFETY COURSE THAT DAY. MAKE SURE THEY REGISTER WITH THE STATE AS CFPMs.

Comply By: 02/06/23

Surface and Equipment Sanitizers

Hot Water: = at 167.9 Degrees Fahrenheit
Location: Dishwasher 1
Violation Issued: No

Hot Water: = at 168.8 Degrees Fahrenheit
Location: Dishwasher 2
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler 1
Temperature: 41.0 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler 1
Temperature: 40.1 Degrees Fahrenheit - Location: Coffeemate
Violation Issued: No

Process/Item: Upright Cooler 2
Temperature: 39.2 Degrees Fahrenheit - Location: Coffeemate
Violation Issued: No

Process/Item: Upright Cooler 3
Temperature: 41.0 Degrees Fahrenheit - Location: Cheese
Violation Issued: No

Process/Item: Upright Cooler 4
Temperature: 32.4 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler 5
Temperature: 41.0 Degrees Fahrenheit - Location: Yogurt
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	1

Type: Full
Date: *01/30/23*
Time: 11:11:49
Report: 1034231017
Diamond Willow Of Detroit Lake

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1034231017 of 01/30/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: McKenna Mathews

McKenna Mathews
Public Health Sanitarian 1
Fergus Falls District Office
218-332-5161
mckenna.mathews@state.mn.us