DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 4, 2023

Licensee
Diamond Willow Of Park Rapids
909 Crocus Hill Street
Park Rapids, MN 56470

RE: Project Number(s) SL25123015

Dear Licensee:

On December 21, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 16, 2022, 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
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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Electronically Delivered

November 28, 2022

Administrator
Diamond Willow of Park Rapids
909 Crocus Hill Street
Park Rapids, MN 56470

RE: Project Number(s) SL25123015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 16, 2022, 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.

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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed 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. 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, Interim 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
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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25123	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PARK RAPIDS	909 CROCUS HILL STREET PARK RAPIDS, MN 56470

(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 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: SL#25123015 On November 14, 2022, through November 16, 2022, 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 23 residents, all whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on November 15, 2022, issued for SL#25123015, tag identification 2310. On November 16, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of three unlicensed personnel (ULP-E) during personal cares, and treatment and medication administration for R7. 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 November 15, 2022, at 7:28 a.m., the surveyor observed ULP-E enter R7's room and don a pair of gloves. ULP-E assisted R7 into the bathroom using a gait belt and walker. ULP-E lowered R7's pants and assisted R7 on to the toilet. ULP-E with gloved hands removed R7's	0 510		

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0 510	Continued From page 2 soiled brief and tossed it into the garbage can. ULP-E removed her gloves and donned a new pair (did not perform hand hygiene after removing her gloves). ULP-E applied a new brief and pad. ULP-E removed her gloves and donned a new pair (did not perform hand hygiene after removing her gloves). ULP-E obtained from the medication cupboard in R7's room a glucometer (a machine for measuring the concentration of glucose in the blood). Using appropriate technique and gloved hands ULP-E performed a glucometer check on R7. ULP-E removed her gloves (did not perform hand hygiene after removing her gloves) and recorded R7's blood glucose results in the electronic record. ULP-E donned a new pair of gloves and proceeded to provide incontinence care. ULP-E using gloved hands and several disposable wipes cleaned R7's bottom and provided peri-care. ULP-E pulled R7's pants up and removed her gloves (did not perform hand hygiene after removing her gloves). ULP-E assisted R7 into her wheelchair and exited the room without performing hand hygiene [hand sanitizer was located outside of each resident room]. ULP-E found another staff member and returned to R7's room. ULP-E obtained R7's insulin pens from the medication cupboard in R7's room and donned a pair of gloves. ULP-E using appropriate technique prepared R7's scheduled morning insulin which was double checked by ULP-F. Using gloved hands, ULP-E administered R7's scheduled morning insulin and checked placement of R7's fentanyl (pain medication) patch. ULP-E removed her gloves (did not perform hand hygiene after removing her gloves) and documented in the electronic record that R7's scheduled morning insulin had been administered. ULP-E proceeded to escort R7 in her wheelchair to the dining room area for breakfast. At 7:52 a.m. the surveyor observed	0 510		

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0 510	Continued From page 3 ULP-E to wash her hands in the kitchen sink. On November 15, 2022, at 8:00 a.m., ULP-E stated she usually washes her hands when she leaves a resident's room. ULP-E stated she did not wash her hands or use hand sanitizer after each time she removed her gloves or between tasks such as providing incontinence care, monitoring R7's blood glucose level, administering R7's insulin and when exiting R7's room to find someone to double check the insulin dose. On November 15, 2022, at 8:40 a.m., registered nurse (RN)-B stated staff should perform hand hygiene after providing incontinence care and each time they remove their gloves. f their hands are really soiled, they should wash their hands with soap and water otherwise they can use hand sanitizer. The licensee's Gloves policy dated September 4, 2022, noted hand washing would be performed by all employees between tasks and procedures, and after bathroom use to prevent cross-contamination. When conducting a procedure requiring the use of gloves, proper hand washing should be completed before donning gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 4 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to prominently post a written emergency preparedness plan. This had the potential to affect all residents, staff, and visitors 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 680		

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0 680	Continued From page 5 or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2022, at 11:26 a.m., a facility tour was conducted with resident assisted living director (RALD)-A. There was no observed signage posted or information regarding the licensee's emergency preparedness plan (EPP) in the common areas of the facility. On November 7, 2022, at 12:23 p.m., RALD-A and registered nurse (RN)-B stated the EPP binder could be found in the locked nursing office. RN-B stated the EPP was not posted in the common areas of the facility and would not be available to residents or visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730		

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0 730	Continued From page 6 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R1) with records reviewed.	0 730		

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0 730	Continued From page 7 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: The licensee's Discharge Resident/Client Roster dated June 14, 2022, to November 14, 2022, indicated R1 was admitted on April 29, 2022, and was discharged on October 8, 2022. R1's diagnoses included dementia, hypertension (HTN-high blood pressure), lower extremity edema, and renal (kidney) insufficiency. R1's service plan dated June 29, 2022, indicated R1 received the following services: medication administration, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. R1's discharge note, dated October 10, 2022, noted R1 had been discharged on October 8, 2022, as she was moving to Arizona with her husband for the winter. R1's record lacked a discharge summary. On November 14, 2022, at 3:18 p.m., resident assisted living director (RALD)-A stated the discharge summary should be completed on the day the resident was discharged or at least by the next day. At 3:30 p.m., registered nurse (RN)-B	0 730		

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0 730	Continued From page 8 stated they did not have a discharge summary for R1 and that it must have been overlooked. The licensee's Client Record policy dated September 4, 2022, noted the resident record must include a discharge summary, including service termination notice and related documentation when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 9 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly 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 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 residents). The findings include: On November 14, 2022, from approximately 11:30 a.m. to 11:55 a.m., survey staff reviewed facility records with Licensed Assisted Living Director (LALD)-A. During the review, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following: Documentation of required employee evacuation drills did not show drills being done every other	0 810		

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0 810	Continued From page 10 month. The schedule and required records on training of employees on fire safety and evacuation. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, relocation. Fire safety and evacuation plans shall be always readily available within the facility. On November 14, 2022, at approximately 11:55 a.m. LALD-A were not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning	01470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PARK RAPIDS	909 CROCUS HILL STREET PARK RAPIDS, MN 56470

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01470	Continued From page 11 and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01470		

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01470	Continued From page 12 Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (registered nurse/RN-B). 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: RN-B was hired on October 11, 2022, to provide direct care to the residents and supervise the staff. RN-B's employee record did not include the following required orientation content: - an overview of the 144 G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints	01470		

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01470	Continued From page 13 - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On November 16, 2022, at 12:02 p.m., RN-B reviewed her employee record and training transcript. RN-B stated she had not completed the assisted living orientation as required. The licensee's Orientation to Home Care Staff policy dated September 4, 2022, noted all comprehensive home care employees must complete the orientation to home care requirements before providing home care services to clients. The licensee did not have an updated assisted living orientation policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	01540		

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01540	Continued From page 14 employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (registered nurse/RN-B) received the required amount of dementia care training in the required time frame. 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: RN-B was hired on October 11, 2022, to provide direct care to the residents and supervise the staff. RN-B's employee records did not indicate a total of 8 hours of required dementia training was completed within 80 hours of the employee's start date. RN-B's employee record indicated the employee had completed 0.75 hours of dementia	01540		

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01540	Continued From page 15 training. On November 16, 2022, at 11:39 a.m., RN-B stated she had worked over 80 hours since her start date in October. At 12:03 p.m., RN-B reviewed her training transcript and stated she had only completed 0.75 hours of dementia training and not the 8 hours that was required. The licensee's ALDC (assisted living dementia care) Additional Dementia Staff Training policy dated September 5, 2022, noted the staff who work with residents with Alzheimer's disease and other dementias have proper training for the tasks assigned. Dementia training will be documented and will indicate staff knowledge and understanding of such training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=D	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	01620		

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01620	Continued From page 16 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 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 ensure the registered nurse (RN) completed a comprehensive reassessment on day 90 for one of two residents (R3) as required 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, 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: R3's diagnoses included hypertension (HTN-high blood pressure), diabetes, anemia, hyperlipidemia (high cholesterol), and developmentally delayed. R3's service plan dated July 17, 2022, indicated the resident received the following services: blood glucose monitoring, medication administration,	01620		

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01620	Continued From page 17 housekeeping, laundry, and assistance with grooming, dressing, toileting, and bathing. On November 15, 2022, at 8:01 a.m., the surveyor observed unlicensed personnel (ULP)-F, using appropriate technique, to conduct a blood glucose check and administer R3's scheduled morning medications which included insulin. R3's record included a comprehensive reassessment using the uniform assessment tool dated July 29, 2022. R3's record lacked documentation of an ongoing 90-day reassessment as required, which was due on October 27, 2022 (19 days overdue). On November 16, 2022, at 9:12 a.m., registered nurse (RN)-B stated "she [R3] was on my list to do this week". RN-B stated she was aware R3's ongoing 90-day reassessment was late. The licensee's Nursing Assessments, Delegated Nursing Services and Supervision Policy and Procedures dated September 4, 2022, noted the RN will reassess each client on an on-going basis and will revise the client's service plan based on the client's needs. The RN will determine the frequency of monitoring and reassessments based on the client's needs and include client monitoring and assessment to not exceed every 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01640	Continued From page 18	01640		
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 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 one of two residents (R4), and failed to ensure the service plan was revised to reflect the current frequency of services provided for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a client's health or	01640		

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01640	Continued From page 19 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 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: SERVICE PLAN DEVELOPMENT R4 R4 was admitted on August 30, 2022 and received services under the licensee's assisted living with dementia care license. R4's diagnoses included hyperlipidemia (high cholesterol), pulmonary embolism (PE- a condition in which one or more arteries in the lungs become blocked by a blood clot), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), lung mass, anxiety, and restless leg syndrome. R4's Master Care Plan dated October 6, 2022, indicated R4 received medication management services to include medication administration, housekeeping, laundry, and assistance with bathing, dressing, transferring, and toileting. On November 15, 2022, at 9:16 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R4's scheduled morning medications except for the scheduled sertraline which was not in R4's medication cupboard. R4's record lacked a service plan.	01640		

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01640	Continued From page 20 On November 16, 2022, at 8:43 a.m., registered nurse (RN)-B stated she was unable to find a service plan developed for R4. She questioned if the previous RN had missed it. SERVICE PLAN REVISION R3 R3's diagnoses included hypertension (HTN-high blood pressure), diabetes, anemia, hyperlipidemia (high cholesterol), and developmentally delayed. On November 15, 2022, at 8:01 a.m., the surveyor observed ULP-F, using appropriate technique, to conduct a blood glucose check. R3's prescriber orders dated March 3, 2022, included an order for blood glucose monitoring to be completed daily. R3's assessment dated July 29, 2022, noted diabetic management services would be provided per prescriber orders. R3's service plan dated July 17, 2022, indicated blood glucose monitoring would be conducted three times daily. On November 16, 2022, at 10:17 a.m., RN-B stated R3's service plan had not been revised to reflect the prescriber orders to conduct blood glucose testing once daily. RN-B stated R3's blood glucose levels can fluctuate quite a bit. 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 home care services to a client. The service plan must be revised, if needed, based on the results of required client monitoring	01640		

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01640	Continued From page 21 and/or reassessments. Service plans are required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

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01730	Continued From page 22 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R4). 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 November 14, 2022, at 10:40 a.m., resident assisted living director (RALD)-A stated the licensee provided medication management services to residents at the facility.	01730		

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01730	Continued From page 23 R4's diagnoses included hyperlipidemia (high cholesterol), pulmonary embolism (PE- a condition in which one or more arteries in the lungs become blocked by a blood clot), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), lung mass, anxiety, and restless leg syndrome. R4's record lacked a service plan. R4's Master Care Plan dated October 6, 2022, indicated R4 received medication management services to include medication administration. R4's prescriber orders dated October 26, 2022, included the following scheduled medications: - acetaminophen (mild pain reliever) 650 milligrams (mg) three times daily - ipratropium 0.5 mg - albuterol 3 mg (2.5 mg/3 milliliter) nebulizer treatment four times daily - sertraline (antidepressant) 100 mg daily - warfarin (blood thinner) 2.5 mg (on Tuesday, Wednesday, Thursday, Saturday, Sunday) - warfarin 3.75 mg (on Monday, Friday) On November 15, 2022, at 9:16 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R4's scheduled morning medications except for the scheduled sertraline which was not in R4's medication cupboard. ULP-G stated she would check with the registered nurse (RN) to see if it had come in yet. On November 15, 2022, at 9:25 a.m., directly following the above observation, ULP-G went to the nursing office and asked RN-G if R4's medication [sertraline] had come in yet. RN-G stated she would notify hospice to see if they were going to bring it in today.	01730		

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01730	Continued From page 24 R4's Coordination of Care agreement dated September 19, 2022, with R4's hospice provider indicated the hospice provider would be responsible for providing R4's medications, supplies and equipment needed to meet R4's needs related to the terminal illness that were not covered in room and board rate. R4's assessment dated October 6, 2022, indicated the facility would be responsible for R4's medication supplies and medication refills. R4's medication management record did not include or was not kept current to include the following: - lacked a written statement on the service plan of the medication management services that will be provided to the resident - lacked identification of medication management tasks that may be delegated to the ULP - had not been kept current to reflect that hospice would now be responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis On November 16, 2022, at 8:49 a.m., RALD-A and RN-B stated they do provide medication management services for R4, and hospice manages R4's medication refills. RALD-A and RN-B stated R4's medication management plan had not been kept up-to-date and did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01770	Continued From page 25	01770		
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 (R9). 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 November 14, 2022, at 10:40 a.m., resident assisted living director (RALD)-A stated the licensee provided medication management services. R9's diagnoses included hypertension (HTN-high blood pressure), heart failure, atrial fibrillation (irregular often fast heartrate), chronic pain, and anxiety. R9's service plan effective November 4, 2022, indicated R9 received medication management services.	01770		

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01770	Continued From page 26 R9's prescriber orders dated November 7, 2022, included an order for morphine concentrate (medication to treat severe pain) 100 milligrams/5 milliliters (mg/ml) 4 mg (0.2 ml) by mouth three times daily. On November 14, 2022, at 11:54 a.m., the surveyor toured the facility with RALD-A, including a review of the locked medication cupboard with unlicensed personnel (ULP)-C. Observed in the medication cupboard was a clear baggie with 14 prefilled syringes labeled with R9's name and identified as morphine 4mg/0.2 ml. ULP-C stated the syringes had been set up by registered nurse (RN)-B and RALD-A [who also holds a licensed practical nurse/LPN license]. On page 140 of the narcotic log book (a bound paper book which documents the removal and addition of the identified controlled substance) it was noted on October 10, 2022, RN-B and RALD-A had "filled 25 syringes x 0.2ml" of morphine for R9. R9'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 November 16, 2022, at 8:27 a.m., RN-B and RALD-A stated they setup R9's morphine syringes together as needed. RALD-A stated they document medication setup on the narcotic log book which was not considered part of R9's medical record. RN-B and RALD-A stated medication setup for R9's morphine had not been documented as required and she was the only	01770		

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01770	Continued From page 27 resident who received medication setup services. The licensee's Medication Administration - Weekly Dosage Box Setup policy dated September 4, 2022, noted 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=F	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	01790		

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01790	Continued From page 28 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed 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	01790		

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01790	Continued From page 29 doses of each returned medication. 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) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of two unlicensed personnel (ULP-C) 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, 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). The findings include: During the entrance conference on November 14, 2022, at 10:43 a.m., resident assisted living director (RALD)-A confirmed the licensee provided medication management services and when the licensed nurse was not available the ULP could prepare and send medications with a resident. UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Administration - Outings and Planned or Unplanned Leaves of	01790		

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01790	Continued From page 30 Absence policy dated September 4, 2022, indicated for unplanned client time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has trained the ULP and determined the ULP to be competent to follow the procedures for giving medications to clients. The RN needs to have developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The licensee's policy lacked a written procedure to include how the ULP 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 medication returned. TRAINING AND COMPETENCY EVALUATIONS ULP-C was hired on February 17, 2022, to provide direct care services for the licensee's residents which included medication administration. On November 15, 2022, at 6:50 a.m., the surveyor observed ULP-C administer R2's scheduled morning medications. ULP-C's employee record lacked evidence to indicate he had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On November 16, 2022, at 12:01 p.m., RN-B and RALD-A reviewed the licensee's policy noted above and stated the procedure did not include instructions for the ULP to follow when unused medications were returned. RN-B reviewed	01790		

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01790	Continued From page 31 ULP-C employee record and stated ULP-C had not been trained or deemed competent to prepare and give medications to residents for an unplanned time away. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 the medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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: On November 14, 2022, at 11:37 a.m., the	01880		

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01880	Continued From page 32 surveyor toured the facility with resident assisted living director (RALD)-A, including a review of the medication refrigerator on the "birch park" unit. RALD-A stated the current temperature of the medication refrigerator was 24-26 degrees Fahrenheit (F). RALD-A stated the medication refrigerator temperatures should be monitored daily. RALD-A was unaware of the acceptable temperature range for the medication refrigerator. The surveyor asked for the November medication refrigerator log. RALD-A looked around the refrigerator area and then stated they did not have one. The refrigerator contained the following medication: - two unopened Basaglar 100 units/milliliter (ml) insulin pens for R6. On November 14, 2022, at 11:45 a.m., the "evergreen" unit medication refrigerator was reviewed with RALD-A. RALD-A stated the refrigerator did not have a thermometer in it, so she was unable to confirm the current temperature. RALD-A stated they did not have a temperature log for this refrigerator either. The refrigerator contained the following medications: - four unopened Lantus 100 units/ml insulin syringes for R7 - three unopened Novolog 100 units/ml insulin syringes for R3 - two unopened Novolog 100 units/ml insulin syringes for R7 - one unopened Levemir 100 units/ml insulin syringes for R3 - two unopened Trulicity 1.5 milligram/0.5 ml pens for R3 The manufacturer's instructions for Basaglar insulin pens dated July 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Basaglar to	01880		

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01880	Continued From page 33 freeze. The manufacturer's instructions for Lantus insulin pens dated December 2019 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog insulin pens dated June 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze. The manufacturer's instructions for Levemir insulin pens dated January 2019 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). The manufacturer's instructions for Trulicity dated June 2022 indicated to store the pens in the refrigerator at 36-46 degrees F. Do not freeze Trulicity. The licensee's Storage of Medications policy dated September 4, 2022, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01910		

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01910	Continued From page 34 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, 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 (R1) 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:	01910		

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01910	Continued From page 35 R1 was admitted for services on April 29, 2022 and was discharged on October 8, 2022. R1's diagnoses included dementia, hypertension (HTN-high blood pressure), lower extremity edema, and renal (kidney) insufficiency. R1's service plan dated June 29, 2022, indicated R1 received medication management services which included medication administration. R1's October 2022, Medication Administration Summary indicated R1 received the following scheduled medications: - Tylenol (mild pain reliever) 650 milligrams (mg) twice daily - Celexa (antidepressant) 10 mg daily - clonidine (sedative/anti-hypertensive) 0.1 mg patch place on once a week (on Monday) - lisinopril 2.5 mg (anti-hypertensive) daily - Ocuvite Lutein (replenishes eye nutrients) 1 capsule daily - risperidone (antipsychotic) 0.5 mg twice daily - Tab-A-Vite (multivitamin) one tablet daily - vitamin D3 one capsule daily - Aricept (a cognition-enhancing medication) 10 mg daily - Melatonin (sleep aide) 5 mg at bedtime R1's prescriber orders dated July 7, 2022, and August 16, 2022, included all the above noted medications. R1's discharge note, dated October 10, 2022, indicated R1 had been discharged on October 8, 2022, as she was moving to Arizona with her husband for the winter. R1's Medication Disposition record dated November 11, 2022, noted the following	01910		

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01910	Continued From page 36	01910		

medications had been disposed of by resident assisted living director (RALD)-A:
- Tylenol 650 mg (112 tablets)
- Celexa 10 mg (28 tablets)
- lisinopril 2.5 mg (28 tablets)
- Melatonin 5 mg (28 tablets)
- risperidone 0.5 mg (56 tablets)
- Tab-A-Vite (28 tablets)
- vitamin D3 (28 tablets)

On November 14, 2022, at 3:24 p.m., RALD-A stated the above noted medications that were disposed of by herself were medications that had been sent to the facility by the pharmacy with their routine 28-day cycle medication delivery. RALD-A stated R1's Ocuvite Lutein and Aricept medications had been given to R1's husband to take with them. RALD-A stated "I'm going to guess that we gave them [husband and R1] all of her medications she was taking that we had left" when she was discharged. RALD-A stated the staff did not document what medications were sent with R1 upon her discharge. At 3:31 p.m., registered nurse (RN)-B stated R1's record did not include documentation of the medications that were given to the resident when she discharged.

The licensee's Disposal of Medication policy dated September 4, 2022, noted current unused medications managed by the licensee will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the licensee, or the medication has been discontinued by the prescriber. Upon disposition, the licensee 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, date of

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01910	Continued From page 37 disposition, and names of staff and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly 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 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	02040		

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02040	Continued From page 38 residents). The findings include: A review of the Hazard Vulnerability Assessment showed global hazards such as fire, gas leaks, and epidemics but did not include hazards or safety risks identified on and around the property. During an interview on November 14, 2022, at 11:55 a.m., the Licensed Assisted Living Director (LALD)-A confirmed during an interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
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 (registered nurse/RN-B), had	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25123	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF PARK RAPIDS	909 CROCUS HILL STREET PARK RAPIDS, MN 56470

(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 39 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). The findings include: The facility was licensed as an assisted living facility with dementia care. During the entrance conference on November 14, 2022, at 10:52 a.m., resident assisted living director (RALD)-A stated RN-B oversaw the dementia care training for staff. RN-B's employee record indicated she had completed 0.75 hours of dementia care training since her hire date of October 11, 2022. RN-B's record lacked evidence of demonstrated competency to be the person in charge of overseeing staff training for dementia care. On November 16, 2022, at 12:04 p.m., RN-B stated she did not have a training certificate to verify knowledge and demonstrate competency related to dementia care. RN-B stated she was unaware of this requirement. The licensee's ALDC (assisted living dementia care) Additional Dementia Staff Training policy	02140		

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02140	Continued From page 40 dated September 5, 2022, noted 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 the Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02310 SS=I	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 three of three residents (R4, R7, R9) with hospital-style bed rails. 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	02310		

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02310	Continued From page 41 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 resulted in an immediate correction order on November 15, 2022, at approximately 12:27 p.m. The findings include: R4 On November 15, 2022, at 8:58 a.m., the surveyor observed R4 laying in her hospital bed. R4's bed had bilateral upper bedrails. The bedrail on the right side of the bed was in the upright position, the bedrail on the left side of the bed was down with the bed positioned up against the sofa. R4's diagnoses included hyperlipidemia (high cholesterol), pulmonary embolism (PE- a condition in which one or more arteries in the lungs become blocked by a blood clot), chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), lung mass, anxiety, and restless leg syndrome. R4's assessment dated October 6, 2022, indicated the resident did not have bedrails or any adaptive/assistive equipment used on her bed. R4 was incontinent of both bowel and bladder and was identified as a fall risk. R4's record lacked a comprehensive assessment on the use of an assistive device and lacked bedrail measurements. R4's record lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative, and lacked information related to	02310		

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02310	Continued From page 42 interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On November 15, 2022, at 10:13 a.m., registered nurse (RN)-B stated bedrail assessments are completed by the RN every 90 days with the ongoing assessments. RN-B stated we make sure the zones of entrapment are less than 4 inches and that the bedrail is safely attached to the bed. We also educate the family and/or resident and provide them the risks and benefits of having a bedrail. RN-B stated R4 uses the bedrail for repositioning and transferring. Resident assisted living director (RALD)-A stated R4 has a hospital bed which she has had since she was admitted. RN-B stated R4 has not had a bedrail assessment completed nor has a risk and benefit discussion been completed with the resident or the resident's representative. On November 15, 2022, at 10:20 a.m., RN-B measured R4's bedrail with surveyor present. The bedrail measured 16 ¼ inches tall by 2 ¼ inches wide, which was in compliance with the FDA guidelines for bedrails. R7 On November 15, 2022, at 7:28 a.m., the surveyor observed R7 seated in a recliner in her room. R7's hospital bed had a bedrail in the down position on the right side of the bed. R7's diagnoses included hypertension, depression, anemia, Alzheimer's disease, atrial fibrillation (irregular often fast heart rate), asthma and sleep disturbance. R7's service plan dated June 29, 2022, indicated the resident received the following services: blood	02310		

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	25123	A. BUILDING: _____ B. WING _____	11/16/2022

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02310	Continued From page 43 glucose monitoring, medication administration, assistance with transferring, grooming, bathing, and toileting. R7's assessment dated October 6, 2022, indicated the resident had bilateral upper bedrails to enable independence with turning and repositioning in bed. Resident does have some short-term memory problems. In addition, it was noted that the bed safety zone assessment was not applicable, because either resident has no bedrails in use or has portable bed rails that are installed on a consumer bed. R7 was identified as a fall risk. R7's record lacked a comprehensive assessment on the use of an assistive device and lacked bedrail measurements. R7's record lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative, and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On November 15, 2022, at 10:20 a.m., RN-B measured R7's bedrail with surveyor present. The bedrail measured 16 ¾ inches tall by 2 ¼ inches wide, which was in compliance with the FDA guidelines for bedrails. The bedrail was securely fastened to the bed. On November 15, 2022, at 11:24 a.m., RN-B stated R7 has not had a comprehensive bedrail assessment completed nor has a risk and benefit discussion been completed with the resident or the resident's representative. R9 R9's diagnoses included heart failure, cerebral	02310		

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02310	Continued From page 44 infarct (occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen), hypertension (HTN-high blood pressure), anxiety, atrial fibrillation, and chronic pain. R9's unsigned service plan indicated R9 received the following services: medication administration, housekeeping, assistance with bathing, toileting, and laundry. R9's bedrail assessment fand bedrail risk/benefit consent/assessment form dated November 4, 2022, indicated R9 has bilateral bedrails on a hospital bed and that a risk and benefit statement had been completed with R9's representative. R9's assessment completed on November 4, 2022, indicated R9 had bilateral half rails on her hospital bed to aide with turning/repositioning, aide for transferring in and out of bed. In addition, the RN would measure and assess the appropriate use and safety of the bedrail. R9 was identified as a fall risk. R9's record lacked a comprehensive assessment on the use of an assistive device to include measurements. On November 15, 2022, at 10:42 a.m., RN-B measured R9's bedrail with surveyor present. The bedrail measured 16 ¾ inches tall by 2 inches wide, which was in compliance with the FDA guidelines for bedrails. The bedrail was securely fastened to the bed. On November 15, 2022, at 11:25 a.m. RN-B stated a comprehensive bedrail assessment had not been completed on R9 to include the measurements of the zones of entrapment. RN-B	02310		

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02310	Continued From page 45 stated she was unaware they needed to include measurements as part of the bedrail assessment. The licensee's Nursing Assessments, Delegated Nursing Services and Supervision Policy and Procedure dated September 4, 2022, noted a bedrail risk assessment will be completed at the time of admission. Education on bedrail safety will also be provided to the client/client's representative/client family as indicated. A bedrail risk assessment will be completed if staff report bedrail use by a client or a client is considering obtaining a bedrail. 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 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	02310		

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02310	Continued From page 46	02310		

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 measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.

OXYGEN STORAGE
On November 14, 2022, at 11:26 a.m. the surveyor toured the facility with RALD-A. The surveyor observed in R5's room 20 short oxygen cylinders. Sixteen of these oxygen cylinders were stored in a heavy cardboard holder on the floor against the wall in the corner of R5's room behind and beside a chair. Three (3) of the oxygen cylinders were positioned directly on the floor in front of the cardboard holder and one of the cylinders was located on top of a counter. These four oxygen cylinders were not securely stored in

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02310	Continued From page 47 a holder or stand. On November 14, 2022, at 11:30 a.m., RALD-A stated all oxygen cylinders should be stored upright and placed in a holder or stand. On November 14, 2022, at 11:39 a.m., the surveyor observed with RALD-A in a storage room one tall oxygen cylinder stored directly on the floor and not secured in a holder/stand. RALD-A stated she didn't know even know where the oxygen cylinder came from and that it should be stored in a holder or stand. On November 14, 2022, at 11:50 a.m., the surveyor observed with RALD-A in a storage room one short oxygen cylinder located on top of a tall filing cabinet. This oxygen cylinder was not secured in a holder/stand. RALD-A stated, "looks like we have a problem with oxygen storage" and removed the oxygen cylinder from the top of the filing cabinet and placed it upright on the floor (not secured in a holder/stand). The licensee's Cylinder (Portable) Oxygen policy dated September 4, 2022, noted oxygen should be stored in a metal rack. Do not store oxygen cylinders in a freestanding, upright position. No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor on November 16, 2022, however, non-compliance remains at a scope and level of three, widespread (I). TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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DEPARTMENT OF HEALTH

Type: Full
Date: *11/14/22*
Time: 11:06:11
Report: 8045221121

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow of Park Rapids
909 Crocus Hill Street
Park Rapids, MN56470
Hubbard County, 29

Establishment Info:
ID #: 0020028
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
TL-DW Park Rapids LLC

Phone #: 2187321671
ID #: 53279

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE (911)
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE (909)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: GRAPES (911)
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: STRAWBERRIES (909)
Violation Issued: No

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: SPAGHETTI SAUCE (911)
Violation Issued: No

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: SPAGHETTI SAUCE (909)
Violation Issued: No

Type: Full
Date: *11/14/22*
Time: 11:06:11
Report: 8045221121
Diamond Willow of Park Rapids

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

THIS ESTABLISHMENT HAS TWO KITCHENS (909 AND 911).

THE MAJORITY OF THE COOKING IS OCCURRING IN KITCHEN 911.

BOTH KITCHENS FOUND CLEAN AND IN GOOD CONDITION AT TIME OF INSPECTION.

APPROVED SANITIZER AND TEST KITS PROVIDED.

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

I acknowledge receipt of the inspection report number 8045221121 of 11/14/22.

Certified Food Protection Manager: CRYSTAL POIROT

Certification Number: FM98409 Expires: 04/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Adam J. Bommersbach

Adam Bommersbach
Public Health Sanitarian
705 5th Street NW, Suite A
(218) 308-21
adam.bommersbach@state.mn.us