Electronically Delivered

April 10, 2023

Licensee
Diamondcrest Senior Living
20500 South Diamond Lake Road
Corcoran, MN 55374

RE: Project Number(s) SL23988015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 23, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

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 55164-097

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,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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: SL23988015-0 On March 20, 2023, through March 23, 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 31 active residents, 19 of whom received services under the Assisted Living license.	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.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 630	Continued From page 1 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual abuse prevention plan with all required content for three of three residents (R1, R2, 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, 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). The findings include: R1 R1 was admitted to the assisted living facility on September 18, 2021. R1's service plan dated July 25, 2022, indicated R1 received assistance with ambulation, transfers, bathing, grooming, dressing, and toileting.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 630	Continued From page 2 On March 21, 2023, at 7:57 a.m., the evaluator observed unlicensed personnel (ULP)-E assist R1 transfer from his wheelchair into the shower where ULP-E assisted R1 with bathing. R1's SL (senior living) Vulnerability Assessment, dated February 13, 2023, lacked: -assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults (VA), and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. R2 R2 was admitted to the assisted living facility on April 27, 2015, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's service plan dated October 8, 2022, indicated R2 received escorts to all meals and events, assistance with transferring, activities of daily living, including application of anti-embolism stockings, and medication and treatment management services. On March 21, 2023, at 7:25 a.m., the evaluator observed ULP-D administer morning medications to R2. On March 21, 2023, at 11:21 a.m., R2 spoke with the evaluator about the care and services she received. R2 stated the biggest things she received help with was medications, help with dressing and putting on the TED (thrombo-embolism-deterrent) stockings and meals, adding she get "lunch and dinner only." R2 also said she needed help dressing and the staff assisted her down to the dining room for meals.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 630	Continued From page 3 R2's SL Vulnerability Assessment, dated February 14, 2023, lacked: -assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults (VA), and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. R7 R7 was admitted to the assisted living facility on March 1, 2014, under the licensee's former comprehensive license and continued with independent living services after the licensee converted to an assisted living license on August 1, 2021. On March 21, 2023, at 9:15 a.m., the evaluator observed R7 seated at table in the dining room with two other residents, finishing breakfast. A short time later R7 ambulated independently using a standing walker from the dining area to her room. During a conversation with the evaluator at 9:22 a.m., R7 stated she managed cares by herself. R7 said she was diabetic, managed her own medications, but said she does get her meals from the facility. R7's SL Vulnerability Assessment, dated July 13, 2022, was incomplete; the document was neither filled out by facility staff nor signed. R7's vulnerability assessment lacked: -assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults (VA) -risk of abusing other vulnerable adults and -statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 630	Continued From page 4 On March 23, 2023, at 11:36 a.m., the director of resident care (DRC)-B reviewed the licensee's blank abuse assessment form and said the resident's potential to abuse others was addressed, but noted the resident's susceptibility to be abused by others was not specifically addressed on their form. DRC-B thought there was an updated form included that assessment but said they would have to look at the form and make changes to address it. DRC-B was aware that since the new assisted living licensure, all residents, including those not receiving services, needed to have an abuse assessment and plan. DRC-B did not know why R7 had no plan, noting it was before her employ at the facility, but said all residents needed one and she and the new leadership were committed to make the corrections. The licensee's Vulnerable Adult Maltreatment policy dated February 2, 2023, indicated an abuse prevention plan will be completed for each resident in assisted living by day 14 after move-in or receipt of services. The policy indicated the abuse prevention plan will include and individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; risk of abusing other vulnerable adults; and specific measures to be taken to minimize the risk of abuse to others and self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 660	Continued From page 5 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screening and medical clearance noting free of TB was documented in the employee record for three of three employees (unlicensed personnel (ULP)-C, ULP-F and director of resident care (DRC)-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, 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	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 660	Continued From page 6 a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment, dated May 11, 2022, indicated low risk. ULP-C ULP-C was hired April 27, 2021, under the licensee's former comprehensive license and began providing direct care assisted living services on August 1, 2021. ULP-C's employee record lacked a documented TB history and symptoms screen. ULP-C's record contained a negative chest X-ray dated October 21, 2020. Although ULP-C's record contained a chest X-ray, the record lacked a documented, positive tuberculin skin test dated prior to the chest X-ray and medical evaluation to rule out a diagnosis of active TB. ULP-E ULP-E was hired January 31, 2022, to provide direct-care services to the licensee's independent and assisted living residents. On March 21, 2023, at 9:05 a.m., the evaluator observed ULP-E administer medications to R8. ULP-E's employee record lacked a documented TB history and symptoms screen. DRC-B DRC-B was hired January 17, 2023, to provide direct care services to the licensee's independent and assisted living residents and provide supervision of the licensee's nursing staff. DRC-B's employee record lacked a documented	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 660	Continued From page 7 TB history and symptoms screen. On March 22, 2023, at 2:35 p.m. the licensed assisted living director (LALD)-A said staff needed to be screened for TB, have that documented, and those records needed to be part of employee's file. LALD-A said they were working with HR (human resources) to be compliant with the content of all employee records. The licensee's Infection Prevention and Control Program Assisted Living Communities: Minnesota policy, dated February 9, 2023, indicated the community will establish and maintain a TB Prevention and control program based on the most current guidelines issued by the Center for Disease Control and Prevention (CDC) and information from the Minnesota Department of Health. The policy directed upon hire all team members are screened for active TB using the baseline screening tool and tested for TB with either a two-step Mantoux or IGRA laboratory blood test. Further, the results of the TB test will be recorded and kept in the team member's medical file. The policy also indicated if a staff member has a positive TST (tuberculin skin test), a chest X-ray and medical evaluation are required to rule out active TB disease before the employee works. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. A chest X-ray should be done after the date	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 660	Continued From page 8 of the positive TST/IGRA (tuberculin skin test/interferon-Gamma release Assay (blood test to diagnoses TB); however, a chest X-ray done within three months prior to the TST/IGRA is acceptable, provide the heath care worker has not been exposed to infectious TB since the chest X-ray and medical evaluation to rule out a diagnoses of infectious TB disease. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 680	Continued From page 9 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, interview, and record review, the licensee failed ensure its emergency preparedness (EP) plan included all required content, review its EP at least annually, or practice and document testing of its plan at least twice annually as required and post exit diagrams in the building. In addition, the licensee failed to evaluate its missing person policy at least quarterly. This had the potential to affect all 31 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 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 20, 2023, at 11:55 a.m., the evaluator requested to view the facility's missing resident plan, emergency plan and any related documentation, which was later provided. EMERGENCY PLAN CONTENT, REVIEW, TESTING AND DOCUMENTATION The evaluators reviewed the licensee's EP Plan,	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 680	Continued From page 10 undated, including numerous policies and procedures. The licensee's plan lacked the following content: -current, all-hazards approach facility assessment; -description of the population served by licensee; -development of additional policies or procedures for: -handling medical documents; -roles declared under a waiver; -EP training program; and -EP testing program for staff and residents, and documentation of training. The plan lacked evidence the licensee's EP plan was reviewed at least annually. The EP plan documentation included a fire evacuation drill, dated January 18, 2023; there was no evidence of other drills. The EP plan lacked a documented training and testing plan and evidence the facility tested its EP plan or conducted and/or participated in any tabletop exercise to test its plan and document the results of testing at least twice annually as required. On March 22, 2023, at 2:10 p.m., licensed assisted living director (LALD)-A talked about the facility's EP plan with the evaluators, stating they joined the emergency coalition and he had been working to condense it. LALD-A spoke about plans to participate with their drills and also practice a full evacuation, with the fire department on site, later this year, although this was not documented. LALD-A admitted he did not know what the licensee did with respect to the EP plan last year and thought the plan had been reviewed by the former executive director, but was unable to provide evidence to support the review. LALD-A stated he has to move forward, pick up where the plan was left and stated, "it will be	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 680	Continued From page 11 done." LACK OF EMERGENCY PLAN AND EXIT DIAGRAMS Following the entrance conference on March 20, 2023, at 1:17 p.m., the evaluators toured the facility with director of resident care (DRC)-B. During the tour, which included review of all floors and evaluator access areas, the evaluators found no posted or displayed facility exit diagrams. On March 22, 2023, at 2:10 p.m., LALD-A stated there should be exit diagrams posted, at least by the elevators. LALD-A acknowledged they were not up at the beginning of the survey and said, "they should be up in about twenty minutes." LALD-A said exit diagrams should be on every floor. MISSING RESIDENT PLAN/POLICY The evaluators also reviewed the licensee's Wandering and Elopement policy, undated, which was included in the EP plan. The policy lacked evidence the assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required. On March 23, 2023, at 12:13 p.m., LALD-A told the evaluators the missing resident plan was signed off most recently on February 22, 2022, but could not find other evidence the plan was reviewed any other time. LALD-A voiced understanding of requirement the missing resident plan needed review by him and the nurse at least quarterly. No further information was provided.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 680	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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, 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, including walls, floors, ceiling, all furnishings, grounds, 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. 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:	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 800	Continued From page 13 On a facility tour on March 23, 2023, from approximately 10:00 a.m. to 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A and the Director of Maintenance (DM)-G it was observed that the trash chute doors on the second, third, and fourth floors did not shut and latch on their own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed in the trash collection room that the fusible link was missing on the sliding, trash chute cover at the bottom of the trash chute system. The fusible link ensures the trash chute cover closes automatically in case of a fire starting in the dumpster below. It was observed, on the fourth floor near apartment 408 and the third floor near apartment 300, that the fire-rated doors to the egress stairs did not close on their own when opened 90 degrees. It appeared that the door sweep was catching on the carpeting and holding the door in the open position. Fire-rated doors to egress stairs should close and positively latch to maintain the fire resistance integrity of the egress stairwell. It was observed in the fourth-floor records storage room near apartment 405 that there was a large hole in the wall. There was insulation, wood wall studs, and plumbing elements visible in the hole. DM-G stated the hole was where plumbing work had been completed, but the wall had not been patched. It was observed in the third-floor conference room closet near apartment 305 that there were two large holes cut into the rated ceiling assembly above the lay-in ceiling. There were structural elements, plumbing elements, and insulation	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 800	Continued From page 14 visible in the holes. DM-G stated the holes were where plumbing work had been completed, but the ceiling had not been patched. LALD-A and DM-G visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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 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.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 810	Continued From page 15 (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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements. This 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: A record review and interview were conducted on March 23, 2023, at approximately 1:30 p.m. with the Licensed Assisted Living Director (LALD)-A and the Director of Maintenance (DM)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 810	Continued From page 16 RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, LALD-A and DM-G verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A and DM-G verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-A and DM-G verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=E	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.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 900	Continued From page 17 (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, 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 interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for three of five residents (R1, R2 and 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, but was not likely to cause serious injury, impairment, or death) and	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 900	Continued From page 18 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: R1 R1 was admitted September 18, 2021, and was receiving assisted living services. R1's service plan dated July 25, 2022, indicated R1 received assistance with ambulation, transfers, bathing, grooming, dressing, toileting, housekeeping, and laundry. R1's record contained a contract dated August 30, 2021, which included both R1's and R1's spouse names on the contract. Also, the agreement listed R1's spouse as having executed the contract. R2 R2 was admitted to the facility on April 27, 2015, and was receiving assisted living services. R2's service agreement, dated October 8, 2022, indicated R2's services included: assistance with activities of daily living, medication management, application and removal of compression stockings, housekeeping, and laundry. R2's Assisted Living Residency Agreement was dated and signed by the resident on April 25, 2015. R8 R8 was admitted to the facility on July 1, 2018, and was receiving assisted living services.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 900	Continued From page 19 R8's service plan, dated August 18, 2022, indicated R8's services included medication administration, housekeeping, and laundry. R8's Assisted Living Residency Agreement was dated and signed by the resident on July 18, 2018. R1, R2, and R8's records lacked current residency agreements with terms concerning the provision of housing and assisted living services. On March 22, 2023, at 2:23 p.m., licensed assisted living director (LALD)-A reviewed R1, R2 and R8's records with the evaluator and said those residents did not have updated, assisted living contracts. LALD-A also said each resident needed their own contract. LALD-A stated since the survey at a sister facility they became aware of contract issues and were working to address those. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 920	Continued From page 20 services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract that included disclosure of the category of assisted living licensure held by the facility for two of two residents (R4, R5). This had the potential to affect all residents. 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: On March 20, 2023, at 11:55 a.m., during the entrance conference, the evaluators requested a	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 920	Continued From page 21 copy of the facility's assisted living contract, which was later provider and reviewed. R4 and R5's assisted living contracts did not disclose the category of assisted living license held by the facility. R4 R4's service agreement, signed March 15, 2023, indicated R4 received services including assistance with activities of daily living, housekeeping, and laundry. R4's Residency Agreement, dated December 30, 2022, lacked content described above. R5 R5's service plan dated March 10, 2023, indicated R5 received medication management services. R5's Residency Agreement, dated March 14, 2023, lacked content described above. On March 22, 2023, at 2:19 p.m., licensed assisted living director (LALD)-A acknowledged the language in the residents' contracts to not fully disclose the kind of license the facility held, and this language was in all current resident contracts. LALD-A stated this had been addressed with regional staff and updated contracts were to be provided for all residents, which had not happened yet. LALD-A stated they would make changes and update all resident contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the contract did not include language requiring a resident to obtain nursing services only from the licensee for two of two residents (R4, R5). This had the potential to affect all residents. 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 930	Continued From page 23 or has potential to affect a large portion or all of the residents). The findings include: On March 20, 2023, at 11:55 a.m., during the entrance conference, the evaluators requested a copy of the licensee's assisted living contract, which was later provider and reviewed. R4 and R5's assisted living contracts included language the resident could not obtain services from an unaffiliated provider. R4 and R5's assisted living contracts included a clause in section 3(e)(1) which indicated "To the extent you need services that we offer, you must obtain those services from us." R4 R4's service agreement, signed March 15, 2023, indicated R4 received services including assistance with activities of daily living, housekeeping, and laundry. R4's Residency Agreement, dated December 30, 2022, included the clause described above. R5 R5's service plan dated March 10, 2023, indicated R5 received medication management services. R5's Residency Agreement, dated March 14, 2023, included the clause described above. On March 22, 2023, at 2:23 p.m., licensed assisted living director (LALD)-A stated he spoke with the licensee's legal team and notified them of the language in the contract and said, "the wording is wrong." LALD-A said this language	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
0 930	Continued From page 24 was in all current resident contracts. LALD-A said the sentence should read: the resident "may" obtain services us. LALD-A stated this had been addressed with regional staff and updated contracts were to be provided for all residents, which had not happened yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01470 SS=E	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 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01470	Continued From page 25 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: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for three of four employees (director of resident care (DRC)-B, unlicensed personnel (ULP)-C and ULP-E). This practice resulted in a level two violation (a	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01470	Continued From page 26 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 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: DRC-B DRC-B started employment January 17, 2023, and was hired to provide assisted living services to the licensee's residents and provide supervision and training for unlicensed personnel. Review of resident records indicated DRC-B completed nursing assessments and developed service plans for the licensee's residents. DRC-B's employee record lacked evidence orientation to assisted living included: -overview of the assisted living statutes; -review of the providers' policies and procedures; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -handling resident complaints, reporting of complaints, where to report; -consumer advocacy services; and -review of types of assisted living services the employee with provide and the provider's scope of license. ULP-C ULP-C started employment on April 21, 2021, under the former comprehensive home care	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01470	Continued From page 27	01470		

license and began providing assisted living services on August 1, 2021. ULP-C was hired to provide direct care services to the licensee's residents.

On March 21, 2023, at 6:26 a.m., the evaluator observed ULP-C transfer R1 from the bed into the bathroom and assist R1 with toileting.

ULP-C's employee record lacked evidence orientation to assisted living included:
-overview of the assisted living statutes; and
-review of the providers' policies and procedures.

ULP-E
ULP-E started employment on January 31, 2023, and was hired to provide direct care services to the licensee's assisted living residents.

On March 21, 2023, at 9:05 a.m., the evaluator observed ULP-E administer medications to R8.

ULP-E's employee record lacked evidence orientation to assisted living included:
-overview of the assisted living statutes; and
-review of the providers' policies and procedures.

On March 23, 2023, at 12:04 p.m., the director of clinical services (DNS)-B said parts of employee orientation had not been completed for ULP-C, ULP-E, or herself. DNS-B said she has come to realize some of the lack of required education happened before taking employment here, adding that employee orientation was something they were addressing and working on.

The licensee's Orientation policy, dated February 9, 2023, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01470	Continued From page 28 before providing services to residents. The policy indicated content would include: -an overview of Minnesota's assisted living law; -introduction and review of agency policies and procedures related to the provision of assisted living services; -emergency and disaster training; -types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and provider's scope of licensure; -maltreatment of vulnerable adults; and -complaint process including contact information for the Ombudsman for long-term care and mental health and disabilities. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01500	Continued From page 29 gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01500	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training for two of two employees (unlicensed personnel (ULP)-C and ULP-E) included all required content. 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 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: ULP-C and ULP-E's employee records lacked evidence their annual training included review of the provider's policies and procedures. ULP-C ULP-C started employment on April 21, 2021, under the former comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C was hired to provide direct care services to the licensee's residents. On March 21, 2023, at 6:26 a.m., the evaluator observed ULP-C transfer R1 from the bed into the bathroom and assist R1 with toileting. ULP-C's employee record lacked content described above.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01500	Continued From page 31 ULP-E ULP-E started employment on January 31, 2023, and was hired to provide direct care services to the licensee's assisted living residents. On March 21, 2023, at 9:05 a.m., the evaluator observed ULP-E administer medications to R8. ULP-E's employee record lacked content described above. On March 22, 2023, at 2:31 p.m., licensed assisted living director (LALD)-A acknowledged ULP-C and ULP-E's annual training lacked review of facility policies and procedures. LALD-A was unsure how the review of policies was incorporated in annual training and this likely was the case for all employees. LALD-A said there was a lack of documented evidence in the employee records and they were working to be compliant on all employees' records. The licensee's Annual Training and Documentation policy dated February 9, 2023, indicated all assisted living employees will complete annual education including review of policies and procedures relating to the provision of assisted living services and how to implement them. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01640	Continued From page 32 (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 service plan was authenticated for one of one resident (R1) who had a revised service plan. 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).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01640	Continued From page 33 The findings include: R1 was admitted on September 18, 2021, and had diagnoses including hypertension and dementia. On March 21, 2023, at 7:57 a.m., the evaluator observed unlicensed personnel (ULP)-E assist R1 transfer from his wheelchair into the shower and assist R1 with a shower. R1's service agreement dated February 13, 2023, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. On March 22, 2023, at 4:17 p.m., director of resident care (DRC)-B said R1's current service plan did not include a signature by the facility, resident, or resident's representative. DRC-B further stated she knows this is a regulation and was working to address this with R1's next assessment in a week. The licensee's Resident Service Plans policy, dated April 1, 2019, indicated the service plan and any revisions to service plans will have a signature or other authentication by the facility and the resident. Service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01650	Continued From page 34 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident service plans included all required content for five of five residents (R1, R2, R4, R8). This had the potential to affect all 19 residents who received assisted living services from the licensee. This practice resulted in a level two violation (a	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01650	Continued From page 35 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: R1 R1's service plan, dated July 25, 2022, indicated R1 received assistance with ambulation, transfers, bathing, grooming, dressing, toileting, housekeeping, and laundry. On March 21, 2023, at 6:26 a.m., the evaluator observed unlicensed personnel (ULP)-C transfer R1 from the bed into the bathroom and assist R1with toileting. R2 R2's service plan, dated October 8, 2022, indicated R2 received services including assistance with activities of daily living, medication management, application and removal of compression stockings, housekeeping, and laundry. On March 28, 2023, at 7:25 a.m., the evaluator observed ULP-D enter R2's room and administer morning medications. R4 R4's service plan, signed March 15, 2023, indicated R4 received services including assistance with activities of daily living, housekeeping, and laundry. On March 21, 2023, at 7:58 a.m., the evaluator	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01650	Continued From page 36 observed ULP-D assist R4 with dressing. R8 R8's service plan, dated August 18, 2022, indicated services included medication administration, housekeeping, and laundry. On March 21, 2023, at 9:05 a.m., the evaluator observed ULP-E administer medications to R8. R1, R2, R4, and R8's service plans lacked the following content: -the schedule and methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. On March 23, 2023, at 11:52 a.m., the director of resident care (DRC)-B reviewed R2's current care plan/service plan with the evaluators and said neither the schedule of resident assessment nor the schedule and method of monitoring staff was described on the form. DRC-B also verified R1, R4 and R8's service plans and said this same template (lacking the description of the methods and frequency of resident assessment and staff monitoring) would be used for all residents receiving services. DRC-B said she learned this had been an issue on sister facility's survey and "we have not" updated our resident care plans here. The licensee's Resident Service Plans policy, dated February 9, 2023, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN (registered nurse) or other licensed health professional. The policy indicated service plans would include the schedule and methods of monitoring reviews or assessments of	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01650	Continued From page 37 the resident and schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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 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	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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 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 license failed to implement its policy regarding wasting of medication for one of five residents (R5) when unlicensed personnel (ULP)-E improperly discarded a dropped medication. 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: R8 was admitted to the facility on July 1, 2018, and received medication management services. R8's service plan, dated August 18, 2022, indicated services included medication administration, housekeeping, and laundry. On March 21, 2023, at 9:05 a.m., the evaluator observed ULP-E administer R5's noon medications which included Bupropion ER (extended release) 150 milligrams (mg) by mouth daily; and Vitamin D3 capsule 50 mcg (micrograms) by mouth daily. Both medications were set up in a medication cup and when ULP-E	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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 39	01690		

handed them to R8, the medication cup was dropped on the floor. ULP-E picked both pills and placed them in the wastebasket in R8's room. ULP-E made a note in R8's chart and prepared a new cup of R8's noon medications. ULP-E administered the pills, charted the administration, sanitized hands, and exited R8's room.

On March 21, 2023, at 9:16 a.m., the evaluator asked ULP-E if throwing medications into the garbage was how she was trained to dispose of spilled or dropped medication. ULP-E stated she couldn't remember how she was trained, but that there used to be a solution to put the pill in to destroy medications.

On March 21, 2023, at 9:19 a.m., the evaluator asked director of resident care (DRC)-B about the procedure for a medication that drops to the floor. DRC-B stated staff document what fell to floor, then re set-up the medication for administration. Staff are supposed to destroy medications in the drug buster solution, per training and policy. In addition, DRC-B stated there was an "extensive training" on medication administration in the past month.

The licensee's Medication Management Guidelines policy dated February 9, 2023, indicated in section O, titled "Loss or Spillage of Medications, Including Controlled Medications: When loss or a spillage of any medication occurs, notation must be made in the resident's medication record explaining the spillage and the actions taken. The policy further directed, a medication that is dropped or spilled will be routinely disposed of unless the resident refuses and if the medication is to be discarded, it must be treated as hazardous waste and must be discarded consistent with the agency's disposal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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 40 policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01730 SS=E	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 (7) any resident-specific requirements relating to documenting medication administration,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01730	Continued From page 41 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 an individualized medication management plan with the required content for two of four residents (R2, R5) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on March 20, 2023, at 11:20 a.m., director of clinical services (DNS)-A stated the licensee provided medication management services to their residents. R2	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01730	Continued From page 42 R2's diagnoses included Parkinson's disease, hypertension, Alzheimer's, chronic obstructive pulmonary disease, depression, and anxiety disorder. R2's Assisted Living Levels and Medication Packages agreement and care plan, signed October 8, 2022, indicated R2 received medication management services. R2's prescriber orders dated February 1, 2023, included a medication to treat blood pressure: Metoprolol Succinate ER (extended release) 50 mg (milligrams), give 1 tablet by moth one time a day. On March 28, 2023, at 7:25 a.m., the evaluator observed unlicensed personnel (ULP)-D enter R2's room to administer morning medications. ULP-D greeted R2 and obtained R2's blood pressure and jotted down 149 over 79 and noted a pulse of 66. ULP-D retrieved medications from a locked cupboard in R2's room then began to set them up for administration. ULP-D compared the instructions on the computer tablet to the labels on the medications blister packs and punched out the pills into a small cup. The blood pressure medication, metoprolol, was one of the medications ULP-D set up for R2. A few minutes later R2 swallowed the pills from the cup and swallowed them with sips of water. ULP-D showed the evaluator the instructions for the administration of the blood pressure medication, which directed to hold if the systolic blood pressure (the top number) was less than 100 and pulse less than 60. There were no additional directions for the ULP. After observing R2 swallow the pills, ULP-D documented the administration in the medication administration record (MAR) in the computer and exited R2's	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01730	Continued From page 43 room. On March 28, 2023, at 7:55 p.m., ULP-D stated for R2 staff had to take blood pressure and get a pulse to know whether to give R2 the blood pressure pill or hold it. ULP-D said that information was not on the MAR, but staff could see it in the computer before giving the medication when they looked up R2's blood pressure medication. ULP-D said the instruction spelled out when to hold R2's blood pressure medication but there were no instructions as to when to notify the nurse. ULP-D said, "I would just document that I held the medication" and write it in the notes why it was held. R2's record lacked evidence of a medication management plan to include: -procedures for staff notifying a RN when a problem arose with medication management services. R5 R5's diagnoses included type 2 diabetes, hypertension, and anxiety disorder. R5's service plan dated March 10, 2023, indicated R5 received medication management services. R5's prescriber orders, dated March 13, 2023, included Insulin Aspart (short acting insulin) 100 Unit/ML (milliliter) and directed 4 units via CeQur device (wearable-patch insulin administration system) before meals plus 2 units per 50 mg/dl (milligrams per deciliter) above 150 before meals. Up to 30 units daily. On March 23, 2023, at 8:23 a.m., R5 talked to the evaluator about his medications, specifically his	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01730	Continued From page 44 insulin. R5 stated he is diabetic and receives insulin and that he had a lot of medication issues going on that affected his blood sugars. R5 state he has "Freestyle" (medical device that collects blood sugar without invasive pricks to the skin) so that he doesn't have to poke himself to get his blood sugar, then "I just tell the staff" what the number is. R5 disclosed that only recently have staff been helping him with his insulin. R5's record lacked evidence of a medication management plan to include: -a statement describing the medication management services that will be provided; -specific resident instructions relating to the administration of medications (for insulin); and -procedures for staff notifying a RN when a problem arose with medication management services. On March 23, 2023, at 11:19 a.m., the director of resident care (DRC)-B addressed R2 and R5's medication plans. DRC-B stated staff were trained to notify the nurse with issues with medications, but said that needs to be on the plan. Regarding R5's blood sugars and insulin, DRC-B stated it has been difficult to straighten out R5's orders because they have had to work with different providers and also when R5 received treatments for cancer, monitoring blood glucose is very difficult and they have only recently begun to assist R5 with his diabetic regimen. DRC-B stated the medication plan should include parameters, specific to the resident, who is responsible to do the tasks and, when to notify a nurse. DRC-B stated, "We're not there yet." The licensee's Resident Self-Administration of Medication/Resident Medication Service	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01730	Continued From page 45 Assessment policy, dated February 9, 2023, indicated the director of resident care will assess the residents' medication management needs and if the resident needs or requests services, the registered nurse (RN) develops a Medication Management individualized Service Plan. The policy indicated the plan would include: -identification of the medication management services to be provided; -identification of any specific instructions regarding the medications administered; -identification of team members responsible for tasks, including tasks delegated to unlicensed staff; and -the procedures for notifying a RN when here is a problem with any medication management service. The licensee's Medication Management Guidelines policy dated April 1, 2019, indicated each community adheres to state-specific laws, regulations, and guidelines with regard to the provision and procedures regarding medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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;	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01790	Continued From page 46 (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 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	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01790	Continued From page 47 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: 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 to residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure two of two employees (ULP-C and ULP-E) were trained and 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 March 20,	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01790	Continued From page 48 2023, at 11:42 a.m., licensed assisted living director (LALD)-A and director of resident care (DRC)-B stated presently 19 of the current 31 residents residing in the facility received medication management services. UNPLANNED TIMES AWAY POLICY AND PROCEDURE FOR ULP The licensee lacked a written procedure to include: - the type of container or containers to be used for the medication appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where 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; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - 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	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01790	Continued From page 49 FOR UNPLANNED TIME AWAY ULP-C ULP-C started employment on April 21, 2021, under the former comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C was hired to provide direct care services to the licensee's residents, including medication administration. On March 21, 2023, at 6:26 a.m., the evaluator observed ULP-C transfer R1 from the bed into the bathroom and assist R1 with toileting. ULP-E ULP-E started employment on January 31, 2023, and was hired to provide direct care services to the licensee's assisted living residents, including medication administration. On March 21, 2023, at 9:05 a.m., the evaluator observed ULP-E administer medications to R8. ULP-C and ULP-E's employees records lacked evidence they had been trained and demonstrated competency to provide medications to residents for unplanned times away from home. On March 23, 2023, at 12:00 p.m., DRC-B spoke with the evaluator about unlicensed staff providing medications for resident leave of absences and stated, "we are developing the procedures" and acknowledged that was not done yet. DRC-B did not know if the procedure described in policy fit this facility. DRC-B said if there was nothing about leave of absence medications in the employee records, then ULP-C and ULP-E had not been trained prior to when I started.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01790	Continued From page 50 The licensee's Medication Management Guidelines, dated February 9, 2023, indicated in section "E" Leave of Absence ("LOA") Medications, our community will provide necessary medications, education, instructions, and support to meet the resident's medication needs when they are away from home, if the community provides assistance with medication. The policy indicated only unlicensed team members that have been trained and have satisfactorily demonstrated competency will be assigned to place medications for an unplanned leave of absence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01910	Continued From page 51 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 medications, 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 for one of one discharged 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 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: R9 admitted was admitted April 2, 2022, and had diagnoses including degeneration of brain, hypertension, and gastro-esophageal reflux (GERD). R9's Service Plan dated February 15, 2023, identified R9 received services of transfers, escorts, bathing, grooming, dressing, medication assistance, laundry, meals, and housekeeping. Physician's orders were requested but were not provided.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01910	Continued From page 52 R9's medication administration record (MAR) dated February 1, 2023, to February 28, 2023, included the following medications: three for high blood pressure, two anti-inflammatorily, one for insomnia, one for GERD, one mild pain reliever, two narcotic pain reliever, and one anti-diarrhea. R9 was discharged on February 25, 2023. R9's record lacked documentation of a disposition of medications upon discharge. On March 22, 2023, at approximately 4:05 p.m., director of resident care (DRC)-B confirmed the licensee did not complete a disposition of medications for R9. DRC-B stated upon discharge, hospice disposed of R9's medications and there was no documentation of that. The licensee's Medication Management Guidelines policy dated April 1, 2019, indicated staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of the medication remaining. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01940	Continued From page 53 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 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 (R2, 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, but was not likely to cause serious injury, impairment, or death) and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01940	Continued From page 54 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: During the entrance conference on March 20, 2023, at 11:22 a.m., director of resident care (DRC)-B stated the licensee provided treatment and therapy services to residents, if they were ordered. R2 R2's diagnoses included Parkinson's disease, hypertension, Alzheimer's, chronic obstructive pulmonary disease, depression, and anxiety disorder. R2's Assisted Living Levels and Medication Packages Agreement and Care Plan, signed October 8, 2022, indicated R2 received services including assistance with activities of daily living, including dressing. The plan indicated staff assisted R2 with compression/TED (thrombo-embolic deterrent, specialized hosiery designed to help prevent edema and blood clots) stockings application in the AM (morning) and taking them off/washing them in the PM (evening). R2's prescriber orders dated February 2, 2023, included antiembolism stockings to apply in the morning and remove at bedtime, every day. On March 21, 2023, at 7:55 a.m., unlicensed personnel (ULP)-D stated R2 needed assistance with ADLs (activities of daily living), escorts to meals and medications. ULP-D said R2 wore	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01940	Continued From page 55 TED hose, that staff put them on in the morning and removed them in the evening before bed. When asked if there were any special instructions relating to R2's TED hose, ULP-D stated only to "put them on, take off and wash." ULP-D said she would look for any skin irritation and any swelling or bruising on R2's legs, document that, then report it to the nurse. On March 21, 2023, at 11:10 a.m., R2 spoke with the evaluator about what services she received living in the facility. R2 said she wore compression socks and that staff "put them on for me in the morning and get them off at night." R2's documentation of services for March 2023, indicated R2 received the treatment of TED hose application daily through March 21, 2023. R2's record lacked a treatment and therapy management plan including the following: -documentation of specific resident instructions relating to the treatment or therapy administration; -procedures to notify a registered nurse (RN) or other licensed health professional when problems arose with treatments or therapies. R5 R5's diagnoses included type 2 diabetes, hypertension, and anxiety disorder. R5's service plan dated March 10, 2023, did not indicate R5 received treatment management services. R5's prescriber orders, dated March 13, 2023, directed to test blood glucose three times a day. On March 23, 2023, at 8:23 a.m., R5 told the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01940	Continued From page 56	01940		

evaluator he is diabetic, took insulin and that he had a lot of medication issues going on that affected his blood sugars. R5 state he has a "Freestyle" (medical device that collects blood sugar without invasive pricks to the skin) so that he doesn't have to poke himself to get his blood sugar, then "I just tell the staff" what the number is. R5 disclosed that only recently have staff been helping him with his insulin.

On March 23, 2023, at 8:43 a.m., ULP-H stated R5 did his own blood sugars from his "freestyle" device and when R5 gives the reading they put that in progress notes. ULP-H showed the evaluator R5's insulin instructions and pointed out there were no blood sugar parameters listed for R5 and "nothing about calling the nurse." ULP-H also said it was not written out that staff are to ask R5 for the blood sugar, and right now, the only place to document it was in progress notes. ULP-H stated up until less than a week ago, R5 had been doing his own blood sugars and insulin.

R5's record lacked a treatment and therapy management plan for blood glucose monitoring that included:
-a list of the treatment or therapy tasks delegated to unlicensed personnel (ULP);
-procedures to notify a registered nurse or other licensed health professional when problems arose with treatments or therapies; and
-resident-specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions.

On March 23, 2023, at 11:19 a.m., DRC-B said the treatment plan for testing of R5's blood sugar was not complete and lacked direction about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23988	A. BUILDING: _____ B. WING _____	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMONDCREST SENIOR LIVING	20500 SOUTH DIAMOND LAKE ROAD CORCORAN, MN 55374

(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
01940	Continued From page 57 getting and documenting the blood sugar. DRC-B stated they have only recently begun providing medication and treatment for R5. DRC-B said there should be parameters so the staff know what R5's low and high blood sugars are and language when to notify the nurse, especially when R5 has his steroid treatments, which makes managing blood sugars challenging. DRC-B also talked about R2's treatment plan and said it lacked procedures to notify the nurse if there was an issue about R2's TED hose. DRC-B stated she would expect staff to look for edema that is more than usual, any discoloration, mottling or skin breakdown and stated that information should be on the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *03/21/23*
Time: 09:00:00
Report: 8087231050

Food and Beverage Establishment Inspection Report

Location:

Diamondcrest Senior Living
20500 South Diamond Lake Road
Rogers, MN55374
Hennepin County, 27

Establishment Info:

ID #: 0037717
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634281981
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 159 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 190 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 177 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 5 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: RICE
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO NURSE EVALUATOR BRUCE MELCHERT.

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 8087231050 of 03/21/23.

Certified Food Protection Manager CINDY HUNNICUTT

Certification Number: FM111058 Expires: 04/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LONNIE PEARSON
KITCHEN MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us