Electronically Delivered

July 16, 2025

Licensee
Diamond Willow Assisted Living
130 West North Road
Cloquet, MN 55720

RE: Project Number(s) SL24425016

Dear Licensee:

On May 20, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 6, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

April 4, 2025

Licensee
Diamond Willow Assisted Living
130 West North Road
Cloquet, MN 55720

RE: Project Number(s) SL24425016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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 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: SL24425016-0 On March 3, 2025, through March 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate correction order was identified on March 4, 2025. The licensee took action to mitigate the risk, however, the correction order remains at a scope and level of isolated, level three (G).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 20 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 580		

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0 580	Continued From page 4 During the entrance conference on March 3, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee's quality management team met on a monthly basis and kept documentation from each meeting. On March 3, 2025, at 11:23 a.m., assisted living director in residency (ALDIR)-A stated they were only able to find quality management activity meeting minutes dated October 2024. ALDIR-A stated since CNS-B started as the new CNS for the licensee in November 2024, the quality management team had not been meeting and did follow through with action plan as scheduled. The licensee's Quality Management Project policy dated January 1, 2025, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions	0 775		

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0 775	Continued From page 5 has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with maintenance (M)-H on March 5, 2025, between 8:30 a.m. and 11:00 p.m. the following deficient conditions were observed: FIRE SPRINKLER SYSTEM: The surveyor observed during record review that the fire sprinkler system had a noted deficiency. The 5-year internal pipe inspection has not been completed. The listed deficiency on the annual report shall be fixed. FIRE RATED DOORS: The surveyor observed that the fire rated doors to both buildings mechanical rooms and laundry rooms did not close and latch under their own power. Also, a fire rated door in the corridor did not close and latch. These doors shall be kept closed and shall close and latch under their own power. The deficient conditions were visually verified by	0 775		

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0 775	Continued From page 6 M-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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) staff 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) Staff 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. (f) Evacuation drills are required for staff 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.	0 810		

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0 810	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the required fire drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on March 5, 2025, at approximately 10:30 a.m. with the clinical nurse supervisor (CNS)-B and assisted living director in residency (ALDIR)-A on the fire drills. FIRE DRILLS: Record review indicated that one fire drill was completed and documented in 2025. They are required to be completed two times per year on each shift and documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 8 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies (BGS) were submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for two of 38 employees (unlicensed personnel (ULP)-E, ULP-F). This had the potential to affect all 20 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01290		

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01290	Continued From page 9 During the entrance conference on March 3, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of the required content of the employee record. The licensee's Staff List dated March 3, 2025, listed ULP-E and ULP-F as current employees of the licensee. R2's February 2025, Medication Administration Record and Services Delivered included ULP-E and ULP-F's initials indicating ULP-E and ULP-F provided care and services to R2. The Department of Human Services (DHS) NetStudy employee roster dated March 3, 2025, did not include ULP-E and ULP-F as current employees of the licensee. ULP-E ULP-E was hired on September 10, 2020, to provide direct care to the residents of the licensee. ULP-E's employee record included a DHS Background Clearance Letter dated July 11, 2019; however, was affiliated with HFID 24424, and not affiliated with the licensee's HFID 24425. ULP-F ULP-F was hired on August 13, 2024, to provide direct care to the residents of the licensee. ULP-F's employee record included a DHS letter dated November 9, 2024, indicated ULP-F continued to have a disqualification, but may provide services at the above named program [licensee's name] HFID 23609 and not affiliated with the licensee's HFID 24425.	01290		

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01290	Continued From page 10 On March 3, 2025, at 1:50 p.m., assisted living director in residency (ALDIR)-A stated ULP-E and ULP-F were not showing up in the DHS NetStudy because they may not have been affiliated under the new company's operating name and HFID number 24425. The licensee's Background Studies policy dated January 1, 2025, indicated using the Minnesota (MN) DHS NetStudy online program, the licensee would initiate a background study on all employees being considered for hire. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have been met. Copies of completed background studies shall be kept in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01420 SS=E	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health	01420		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01420	Continued From page 11 professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) provided written instructions in the resident's record for the delegated task provided by the unlicensed personnel for two of two residents (R2, R3) who received delegated nursing tasks. 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 3, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided delegated nursing services to residents at the assisted living facility. R2 On March 3, 2025, at 12:41 p.m., the surveyor observed unlicensed personnel (ULP)-D monitor and record R2's weight of 145 pounds (lbs). R2's diagnoses included ST-elevation myocardial infarction (heart attack).	01420		

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	24425	A. BUILDING: _____ B. WING _____	03/06/2025

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01420	Continued From page 12 R2's Service Plan-Addendum to Contract dated February 25, 2025, indicated R2 was to receive daily weights. R2's prescriber orders dated February 27, 2025, included monitor R2's weight daily for two weeks to establish a baseline, then weekly. R2's Individualized Treatment and Therapy Plan printed March 3, 2025, did not include monitoring R2's weight daily. On March 3, 2025, at 10:03 a.m., ULP-D viewed R2's electronic medical record and stated R2 did not have weight parameters in place for staff to notify the nurse or provider. On March 5, 2025, at 12:51 p.m., CNS-B stated R2's provider ordered daily weights for R2 to establish a baseline and did not set parameters for R2's weight. CNS-B stated R2's service plan included daily weights and was considered a treatment/therapy service and the licensee should have either requested weight parameters from R2's provider or put parameters in place for staff to notify the nurse if R2 had a significant weight loss or gain. R3 On March 4, 2025, at 8:15 a.m., the surveyor observed ULP-J provide R3's morning personal cares. R3 was observed wearing heel and elbow protectors and had a padded dressing to R3's coccyx (tailbone) dated February 25, 2025. ULP-J stated R3 wore the heel and elbow protectors all the time except during dressing or bathing and R3's coccyx dressing was in place to protect R3's skin. ULP-J stated the nurses managed R3's dressing unless the nurse was not	01420		

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01420	Continued From page 13 onsite then the ULPs changed R3's dressing if the dressing was soiled or was falling off. R3's diagnoses included hypertension (high blood pressure), chronic kidney disease (CKD), seizure disorder, congested heart failure (CHF), and anxiety. R3's Service Plan-Addendum to Contract dated June 24, 2024, indicated R3 received assistance with medication administration, bathing, dressing, grooming, toileting, transfers, housekeeping and laundry. R3's prescriber orders dated March 12, 2024, did not include orders for R3's heel and elbow protectors or dressing to coccyx. R3's February and March 2025 Medication Administration Summary did not include R3's heel and elbow protectors or R3's coccyx dressing. On March 5, 2025, at 10:28 a.m., ULP-L reviewed R3's electronic medical record and stated there were no written instructions in R3's record for heel and elbow protectors or dressing. On March 5, 2025, at 11:08 a.m., CNS-B stated she was unaware R3 had heel and elbow protectors or a padded dressing on R3's coccyx. CNS-B stated R3 was on hospice and maybe hospice ordered R3's heel and elbow protectors and dressing and would have to discuss further with staff. CNS-B stated R3's record did not include written instructions for ULPs to manage R3's heel and elbow proctors or instructions for R3's coccyx dressing. CNS-B stated if a resident had treatment or therapy services, there would be written instructions in the resident's record for staff to follow.	01420		

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01420	Continued From page 14 The licensee's Medication and Treatment-Administration and Delegation policy dated January 1, 2025, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel (ULP), the licensee would ensure that the registered nurse has: -instructed the in the proper methods with respect to each resident to administer the medications or perform treatments/therapy , and the ULP has demonstrated the ability to competently follow the procedures; -specified, in writing, specific instruction for each resident and documented those instructions in the resident's records; and -communicated with the ULP about he individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 15 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident reassessments and monitoring not to exceed every 90 days from previous assessments and complete a comprehensive assessment with a change in condition for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 3, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the RN conducted resident assessments for pre-admission, on admission,	01620		

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01620	Continued From page 16 14-days after admission, every 90 days or sooner with changes in resident condition. On March 4, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-J assist R3 with personal cares. R3's Face Sheet dated June 24, 2024, indicted R3's assisted living services were initiated March 12, 2024, and R3's diagnoses included hypertension (high blood pressure), chronic kidney disease (CKD), seizure disorder, congested heart failure (CHF), and anxiety. R3's Service Plan-Addendum to Contract dated June 24, 2024, indicated R3 received assistance with medication administration, bathing, dressing, grooming, toileting, transfers, housekeeping and laundry. R3's records included an admission assessment dated March 3, 2024, a 14-day assessment dated March 19, 2024, and a 90-day assessment dated June 25, 2024; however, R3's record lacked evidence the RN completed ongoing assessments after R3's last assessment completed June 25, 2024. On March 5, 2025, at 11:08 a.m., CNS-B stated resident assessments were completed in RTasks (electronic medical record) and after a resident assessment was completed, the next assessment due date was entered into RTasks and RTasks would alert when the next resident assessment was due. CNS-B stated the previous CNS entered R3's next assessment due date incorrectly in RTasks and scheduled R3's assessment due for March 2025, a year after R3's last assessment instead of 90 days. CNS-B stated they were not aware R3's assessments	01620		

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01620	Continued From page 17 were out of compliance until the surveyor requested R3's past two completed assessments to review. CNS-B stated after they discovered R3 had not had an updated assessment, CNS-B completed R3's assessment March 4, 2025, which generated a new service plan due to a change in R3's condition and an increase in service needs. The licensee's Assessment, Reviews and Monitoring policy dated January 1, 2025, indicated ongoing assessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days form the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with a legible prescription label and information including the opened date and expiration date for time sensitive medications for	01890		

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01890	Continued From page 18 one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 4, 2025, at 7:36 a.m., the surveyor observed unlicensed personnel (ULP)-K prepare R2's morning medications. ULP-K retrieved a Novolog (rapid-acting) insulin pen from the medication cart, primed two units of insulin then dialed six units of insulin for administration. The surveyor observed the Novolog insulin pen without an original prescription label and observed a sticker that was not legible or indicated a resident name or date the insulin had been opened or would expire. ULP-K stated she normally worked the night shift and was not familiar with R2's insulin. ULP-K stated she did not notice the Novolog insulin pen did not have a legible label with the name of the resident or the date the insulin was opened or would expire until the surveyor requested to observe the Novolog insulin pen. R2's diagnosis included diabetes type II. R2's service plan dated February 25, 2025, indicated R2 received medication administration. R2's prescriber orders dated February 27, 2025, included Novolog FlexPen six units of insulin twice a day and eight units of insulin at bedtime.	01890		

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01890	Continued From page 19 R2's March 2025 Medication Administration Summary indicated R2 was scheduled and received Novolog insulin six units at 8:00 a.m., and 5:00 p.m., and eight units at bedtime. On March 4, 2025, at 7:48 a.m., clinical nurse supervisor (CNS)-B stated R2 was a new resident to the licensee as of last week and came with insulin pens from a previous provider. CNS-B verified R2's Novolog FlexPen did not have a legible label to identify the resident name or date the insulin pen had been opened and would expire. CNS-B stated R2 had unopened insulin in the medication refrigerator and would discard R2's opened Novolog insulin pen to avoid further use and obtain a new one. CNS-B stated staff should notify nursing if a prescription label was not present or the prescription label was not legible so the nurse could contact the pharmacy for a new prescription label. The manufacturer's instructions for Novolog FlexPen dated March 2021, indicated to discard 28 days after opened even if it still has insulin left in it. The licensee's Medication Storage policy dated January 1, 2025, indicated medications would be stored consistent with manufacturer's recommendations. The licensee's Medication Management-Administration and Setup policy dated January 1, 2025, indicated all medications and multi-dose containers must be labeled with the date they are opened and the corresponding expiration date on manufacturer guidelines or regulatory standards. Staff were to ensure all entries are clear and legible to avoid confusion	01890		

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01890	Continued From page 20 during medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, 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 record all required content in the disposition of medications for one of one resident (R1) upon discharge.	01910		

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01910	Continued From page 21 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: R1's diagnoses included congestive heart failure, confusion, diabetes, multiple myeloma, neuropathy (nerve damage) and cardiac pacemaker. R1's December 2024 Medication Administration Summary indicated R1 was scheduled and received the following medications: -atenolol 25 milligrams (mg) one table daily for high blood pressure; -diltiazem CD 360 mg one tablet daily for chest pain; -furosemide 20 mg one tablet daily for swelling; -multivitamin one tablet daily for supplementation; -omeprazole 20 mg one capsule daily for heart burn; -potassium chloride 10 milliequivalents (meq) for low potassium levels; -sotalol 80 mg one tablet twice daily for irregular heart rate; -metformin 500 mg one tablet daily for high blood sugar levels; and -gabapentin 100 mg one capsule at bedtime for nerve pain; R1's prescriber orders dated August 27, 2024, included above noted medications. R1's Discharge/Transfer Summary dated	01910		

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01910	Continued From page 22 December 19, 2024, indicated R1 was admitted August 19, 2024, and discharged to home December 14, 2024. R1's discharge summary indicated R1 received medication management services and R1's medications were sent with R1 at discharge. R1's Current Medications at Discharge dated December 19, 2024, included documentation for the disposition of the medications noted above of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition; however, lacked documentation of the medication prescription number, as applicable. On March 4, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated R1's medication disposition record did not include the medication prescription numbers as required. CNS-B they had not been documenting the medication prescription numbers prior to the recent change to pharmacy connect where the prescription numbers were automatically included on the medication disposition record in Rtasks (electronic medical documentation system). The licensee's Medication Disposal policy dated January 1, 2025, indicated current unused medications being managed by the licensee would be returned to the pharmacy for credit, or given to the resident or resident's representative, when the resident's medications were no longer managed by the facility, or the medication have been discontinued by the provider. Upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medications name, strength, prescription number as applicable,	01910		

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01910	Continued From page 23 quantity, date of the disposition, and names of staff and other individuals involved in disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02040		

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02040	Continued From page 24 or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 5, 2025, at approximately 10:30 a.m. with the clinical nurse supervisor (CNS)-B and assisted living director in residency (ALDIR)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. The surveyor observed during the tour that the fireplace in the commons area was operating and the protective screen was very hot to the touch and that the doors to the kitchen area were not locked when staff was not present exposing the residents to hazards in the kitchen. (knives/hot stove top/scissors etc.). This fireplace and kitchen locking procedures mitigation factors shall be listed in the hazard vulnerability assessment. This deficient condition was verified by CNS-B and ALDIR-A during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

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02310	Continued From page 25 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) who utilized a hospital bed with attached bed rails. In addition, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safety of oxygen storage. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: BEDRAILS During the entrance conference on March 3, 2025, at 9:47 a.m., clinical nurse supervisor (CNS)-B stated the registered nurse (RN) completed bed rail assessment at the time of initiating bed rails and every 90 days. R3's diagnoses included functional limitations, hypertension (high blood pressure) chronic kidney disease, weakness, congestive heart failure and difficulty walking.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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
02310	Continued From page 26 On March 4, 2025, at 8:12 a.m. the surveyor observed upper bed rails in the upright position, attached to both sides of R3's hospital bed. R3's Service Plan-Addendum to Contract dated June 26, 2024, indicated R3 required assistance with bathing, dressing, grooming, eating, toileting, transfers, medication administration, laundry and housekeeping. R3's record indicated on March 24, 2024, at time of R3's admission, a Guide to Bed Safety was provided to R3's representative. R3's comprehensive assessment dated June 25, 2024, indicated R3 was dependent on staff for turning and repositioning, had an electric bed with attached upper side rails, and included measurement of the entrapment zones. R3's record included a delivery ticket from a medical supply company dated January 20, 2025, indicated R3 had the following medical equipment delivered: -semi-electric bed with mattress; and -half-length bed rails. R3's record lacked continued monitoring for the need and safety of R3's bed rails and further lacked documentation the RN completed a new assessment for R3's new hospital bed with attached bed rails to included measurements for the entrapment zones according the to the Food and Drug Administration (FDA), and R3's bed rails were installed per manufacturer's recommendations. On March 3, 2025, at 1:20 p.m., CNS-B stated R3's last comprehensive assessment completed	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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
02310	Continued From page 27 was June 25, 2024, by the previous RN and stated the previous RN had set R3's next assessment due a year from later and not 90 days from R3's last assessment on June 25, 2024. CNS-B stated R3 did not have a comprehensive assessment since June 2024. On March 3, 2025, at 1:37 p.m., CNS-B stated R3's new hospital bed with attached bed rails was delivered on January 20, 2025, had not been assessed. The Minnesota Department of Health (MDH) website updated April 3, 2024, Assisted Living Resources & Frequently-Asked Questions (FAQs), last updated December 13, 2024, indicated: To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc. Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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
02310	Continued From page 28 (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame. The licensee's Side Rail policy dated January 1, 2025, indicated when a resident or their representative request the use of a bed rail device, the licensee would assess the resident's cognitive and physical abilities, educate the resident and their representative on bed rail risk, and ensure compliance with the FDA's 2006 dimensional guidance to reduce entrapment risks. All bed rails and mobility devices would be checked against the FDA recall list, and manufacturer instructions would be maintained on file. Alternative solution to bed rails should be explored whenever possible to minimize safety risks. Upon placemen of any bed rail or mobility device, an RN would assess the residents cognitive and physical abilities, including their ability to call for help if entrapment occurs. Staff would be educated on the risks associated with bed rails and mobility devices, recognizing changes in the resident's condition, and monitoring for malfunctioning or unsafe devices. Staff would also be trained in alternative approaches to positioning and fall prevention that do not involve bed rail use. OXYGEN STORAGE During the facility tour on March 3, 2025, at 11:24 a.m., with CNS-B, the surveyor observed one small oxygen cylinder stored on the floor in the food storage room, located off the main entrance of the 132 house. CNS-B stated she was unsure why the oxygen cylinder was stored with the food	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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
02310	Continued From page 29 storage or who the oxygen cylinder belonged to. In addition, the oxygen cylinder was not securely in a rack. The licensee's Oxygen policy dated August 1, 2025, indicated to keep oxygen cylinders and vessels stored upright at all times in a well-ventilated area (not in closets, behind curtains, or other confined spaces). The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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
02410	Continued From page 30 unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of two residents (R2) observed during blood glucose (blood sugar) monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 3, 2025, at 9:37 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided blood glucose monitoring for the licensee's residents. R2's diagnosis included diabetes type II.	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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
02410	Continued From page 31 R2's service plan dated February 25, 2025, indicated R2 received blood glucose monitoring four times a day. R2's prescriber orders dated February 27, 2025, included blood glucose monitoring four time a day. On March 3, 2025, at 11:49 a.m., the surveyor observed unlicensed personnel (ULP)-D obtain a blood glucose meter from the medication cart, walk over to R2 sitting at the dining table, poke R2's right pointer finger, obtain a sample of blood onto the test strip, enter the test strip into the blood glucose meter and attain a blood glucose reading of 147 milligrams per deciliter (mg/dl). At the time R2's blood glucose was monitored, R2 was sitting at the dining table with three other residents eating breakfast. ULP-D did not ask R2's permission to check R2's blood glucose in a public setting or give R2 the opportunity to choose to have his blood glucose checked in a private setting. On March 5, 2025, at 1:35 p.m., CNS-B stated staff were trained to complete all treatments including blood glucose monitoring in a private setting. CNS-B stated staff should have either checked R2's blood glucose before going to breakfast or asked R2 to go back to his room to ensure R2's privacy was respected. The licensee's Blood Sugar Testing-Shared Equipment Use dated January 1, 2025, directed to provide privacy for the procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24425	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	130 WEST NORTH ROAD CLOQUET, MN 55720

(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

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/06/25*
Time: 10:30:00
Report: 1027251034

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Cloquet - Building 130
130 West North Road
Cloquet, MN55720
Carlton County, 09

Establishment Info:
ID #: 0039218
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2188781972
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

AT TIME OF INSPECTION THE ILLNESS LOG BEING KEPT HADN'T BEEN UPDATED SINCE 2021. A NEW ILLNESS LOG WAS LEFT WITH STAFF. COS

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Type: Full
Date: *03/06/25*
Time: 10:30:00
Report: 1027251034

Food and Beverage Establishment Inspection Report

Diamond Willow Of Cloquet - Building 130

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: EGGS
Violation Issued: No

Process/Item: Chest Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Cooking
Temperature: 178 Degrees Fahrenheit - Location: GROUND BEEF
Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

IF RAGS ARE USED TO CLEAN COUNTERTOPS THEN THEY WILL NEED TO BE KEPT IN AN APPROVED SANITIZER SOLUTION SUCH AS QUATERNARY AMMONIA.

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

I acknowledge receipt of the MN Department of Health inspection report number 1027251034 of 03/06/25.

Certified Food Protection Manager: MADISON PALLIN

Certification Number: FM122430 Expires: 03/06/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
MADISON PALLIN
MANAGER

Signed: Ian Harrison
Ian H

651-201-4500
health.foodlodging@state.mn.us

Report #: 1027251034

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/06/25
Time In 10:30:00
Time Out

Diamond Willow Of Cloquet Building 130	Address 130 West North Road	City/State Cloquet, MN	Zip Code 55720	Telephone 2188781972
License/Permit # 0039218	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status			COS	R
Supervision				
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
Employee Health				
3	IN (OUT)	Mgmt/Staff;knowledge,responsibilities&reporting	X	
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices				
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands				
8	(IN) OUT N/O	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
Approved Source				
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination				
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status			COS	R
Time/Temperature Control for Safety				
18	(IN) OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT (N/A) N/O	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory				
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations				
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances				
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures				
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/06/25

Inspector (Signature) Dan Harrison

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/06/25*
Time: 11:00:00
Report: 1027251035

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Cloquet - Building 132
130 West North Road
Cloquet, MN55720
Carlton County, 09

Establishment Info:
ID #: 0039218
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2188781972
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

THE ILLNESS LOG BEING KEPT HAD NOT BEEN UPDATED SINCE 2021. A NEW ILLNESS LOG WAS LEFT WITH STAFF. COS

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 166 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: BUTTER
Violation Issued: No

Type: Full
Date: *03/06/25*
Time: 11:00:00
Report: 1027251035

Food and Beverage Establishment Inspection Report

Diamond Willow Of Cloquet - Building 132

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Cooking
Temperature: 172 Degrees Fahrenheit - Location: LASAGNA
Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

IF RAGS ARE USED TO CLEAN COUNTERTOPS THEN THEY MUST BE HELD IN AN APPROVED SANITIZER LIKE QUATERNARY AMMONIA.

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

I acknowledge receipt of the MN Department of Health inspection report number 1027251035 of 03/06/25.

Certified Food Protection Manager: MADISON PALLIN

Certification Number: FM122430 Expires: 03/06/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ALLISON STONEMARK
MANAGER

Signed: Ian Harrison
Ian H

651-201-4500
health.foodlodging@state.mn.us

Report #: 1027251035

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/06/25
Time In 11:00:00
Time Out

Diamond Willow Of Cloquet Building 132	Address 130 West North Road	City/State Cloquet, MN	Zip Code 55720	Telephone 2188781972
License/Permit # 0039218	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	IN	(OUT)			Mgmt/Staff;knowledge,responsibilities&reporting	X	
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	(IN)	OUT	N/A	N/O	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

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			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/06/25

Inspector (Signature) Dan Harrison