DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 23, 2023

Licensee
Diamond Willow Of Mountain Iron
8583 Unity Drive
Mountain Iron, MN 55768

RE: Project Number(s) SL24664015

Dear Licensee:

On January 6, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Fax: 218-332-5196

PMB

Electronically Delivered

October 28, 2022

Administrator
Diamond Willow Of Mountain Iron
8583 Unity Drive
Mountain Iron, MN 55768

RE: Project Number(s) SL24664015

Dear Administrator:

On October 13, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on August 11, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the August 11, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 11, 2022, found not corrected at the time of the October 13, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

2070-Awake Staff Requirement-144g.81 Subd. 4 - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on October 13, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on October 13, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $3,000.00

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at 218-332-5175.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	R 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF MOUNTAIN IRO	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SI24664015 On October 12, 2022, through October 13, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 11, 2022. At the time of the survey, there were 22 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{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.	
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate order, tag identification 2070, during a survey completed on August 11, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 340		

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0 340	Continued From page 2 has affected or has potential to affect a large portion or all of the residents). The findings include: On August 8, 2022, the Minnesota Department of Health completed a survey resulting in 17 correction orders issued and an immediate order 2070, issued on August 9, 2022. During the revisit survey on October 12, 2022, through October 13, 2022, the surveyor reviewed the licensee's policies and procedures, staffing schedules, staffing plan, conducted observations and interviews with clinical nurse supervisor (CNS)-B, and unlicensed personnel (ULP)-G, ULP-H, ULP-J, ULP-K, ULP-L, ULP-M, ULP-N, ULP-O and ULP-P. The licensee lacked evidence to indicate order 2070 issued on August 9, 2022, was corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	{0 510}		

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{0 510}	Continued From page 3 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}		
{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: No further action required.	{0 580}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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	{0 660}		

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{0 660}	Continued From page 4 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: No further action required.	{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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	{0 680}		

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{0 680}	Continued From page 5 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of	{01470}		

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{01470}	Continued From page 6	{01470}		

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 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,

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{01470}	Continued From page 7 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: No further action required.	{01470}		
{01540} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01540}		

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{01620}	Continued From page 8	{01620}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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: No further action required.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	{01640}		

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{01640}	Continued From page 9 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	{01760}		

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{01760}	Continued From page 10 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: No further action required.	{01830}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	{01910}		

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{01910}	Continued From page 11 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: No further action required.	{01910}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action required.	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	R 10/13/2022

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{02070}	Continued From page 12	{02070}		
{02070} SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured dementia care units. This had the potential to affect all residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 26 residents and had a current census of 22 residents.	{02070}		

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{02070}	Continued From page 13 The licensee failed to ensure one or more staff were always available during all shifts in each of the two separate secured dementia care units. As noted during the initial survey completed on August 11, 2022, the physical layout of the facility consisted of two units (Leonidas and Wacoutah) connected by a link (large community room). Each unit consisted of a hallway, which measured approximately 139 feet in length. The link approximately 51 feet in length and was separated by fire exit doors, which required a key code to open. The Wacoutah unit had 10 resident rooms, occupied by 10 residents. The Leonidas unit also had 10 resident rooms, occupied by 12 residents. On October 11, 2022, the surveyor called the facility and spoke with clinical nurse supervisor (CNS)-B and requested a list of current residents, staff, the licensee's staffing plan, and staff schedules for the month of October 2022, for review for follow up survey. On October 11, 2022, the requested documents were provided via email by CNS-B; however the licensee's staffing schedules provided dated September 30, 2022, through November 3, 2022, did not accurately reflect the actual numbers of staff whom had worked. On October 12, 2022, at approximately 9:30 p.m., the surveyor entered the facility. Unlicensed personnel (ULP)-M and ULP-N were observed working on the Leonidas unit obtaining the mechanical lift from the laundry room to assist R8 with a transfer. On October 12, 2022, at approximately 9:52 p.m.,	{02070}		

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{02070}	Continued From page 14 ULP-M and ULP-N stated there was five (5) residents on Leonidas unit that required a two (2) person transfer assistance with the use of a mechanical lift (a device used to assist with transfers). ULP-M and ULP-P confirmed they both have recently worked where there were only two (2) staff in the facility for either a partial shift or an entire shift and had to leave their secured unit unattended to assist on the other unit either for a narcotic count or to assist with a resident transfer. On October 12, 2022, at approximately 9:54 p.m., the surveyor entered Wacoutah unit where ULP-L and ULP-K were working. ULP-K confirmed there were 10 current residents on Wacoutah and two residents required a two person transfer with the use of a mechanical lift. ULP-L stated since the licensee's last state survey, staff were told there needed to be a minimum of three staff scheduled at all times to avoid leaving the secured units unattended. On October 12, 2022, at approximately 10:07 p.m., ULP-L confirmed she has worked when there were three staff scheduled and one staff would leave early, leaving only two staff for a partial shift, usually on the 2:30 p.m. to 10:30 p.m. shift and sometimes from 4:00 p.m. to 6:00 p.m. ULP-L stated there have been issues filling the shifts so staff filled in where they could, working a double, or coming in for a partial shift. On October 12, 2022, at approximately 10:27 p.m., ULP-G stated she worked the 10:30 p.m. to 6:30 a.m., shift and confirmed every shift should have a minimum of three staff scheduled. ULP-G stated in the past few months there have been a few times when there were only two staff scheduled on the night shift. ULP-G confirmed	{02070}		

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{02070}	Continued From page 15 she has had to leave the unit unattended to assist with a transfer on Wacoutah. On October 12, 2022, at approximately 10:45 p.m., ULP-H confirmed she worked the 10:30 p.m. to 6:30 a.m., shift and there have been a couple occasions where only two staff were scheduled on the night shift, sometimes for the entire shift or for partial shift. ULP-H stated she has had to summons staff from Leonidas unit to come and assist with a resident transfer, leaving the secured unit unattended. During an interview with CNS-B, assistive living coordinator (ALC)-O and ALC-P, on October 13, 2022, at approximately 9:51 a.m., CNS-B confirmed the current census was 22. CNS-B stated since the last survey on October 8, 2022, the licensee has been staffing with a minimum of three direct care staff in facility at all times, and there had been no shifts where there were only two staff in the facility. The surveyor reviewed daily schedules with CNS-B, ALC-O and ALC-P, and the surveyor identified the following dates where there were only two staff scheduled in the facility on the night shift: -Monday, October 3, 2022, 10:30 p.m., to 6:30 a.m., shift only had two staff scheduled; and -Monday, October 4, 2022, 10:30 p.m., to 6:30 a.m., shift only had two staff scheduled. On October 13, 2022, at approximately 9:56 a.m., CNS-B and ALC-O confirmed with the schedule, only two staff worked Monday, October 3, and 4, 2022, from 10:30 p.m., to 6:30 a.m. and there was not a "float" staff scheduled. CNS-B stated she would verify with actual time cards and send the surveyor the information. On October 13, 2022, at approximately 3:40 p.m.,	{02070}		

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{02070}	Continued From page 16 the surveyor received timecard reports via email from CNS-B, which confirmed on October 3, and 4, 2022, only two staff worked the night shift (10:30 p.m.-6:30 a.m.,) and there was no float. The undated licensee's Staffing Plan, indicated to adequately care for the 22 clients residing in the facility, both acuity and census must be accounted. Based on the current acuity and census, the staffing grid indicated between the hours of 10:30 p.m. and 6:30 a.m., there would be two staff and a float. No further information was provided.	{02070}		
{02140} SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: No further action required.	{02140}		
{02350} SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced	{02350}		

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{02350}	Continued From page 17 by: No further action required.	{02350}		

Electronically Delivered

August 24, 2022

Administrator
Diamond Willow of Mountain Iron
8583 Unity Drive
Mountain Iron, MN 55768

RE: Project Number(s) SL24664015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

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

HHH

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 24664015 On, August 8, 2022, through August 11, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 17 residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on August 9, 2022, issued for SL#24664015, tag identification 2070. On August 11, 2022, the immediacy of correction order 2070 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of two unlicensed personnel (ULP)-D and ULP-I by disinfecting shared equipment in between residents use. 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). Findings include: On August 11, 2022, at 8:49 a.m., the surveyor observed ULP-D and ULP-I transfer R7 from her bed into her wheelchair with the use of a mechanical lift (a device used to aide in transfer of persons with limited weight bearing ability) and proceeded to assist R7 with morning cares and	0 510		

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0 510	Continued From page 2 dressing. After the transfer and R7's morning personnel cares were completed, ULP-D brought the mechanical lift out of R7's room and brought it into R2's room without disinfecting the mechanical lift. On August 11, 2022, at approximately 9:27 a.m., ULP-D stated she did not think about disinfecting the mechanical lift in between resident use. ULP-D stated the mechanical lift should have been wiped down with disinfecting wipes. On August 11, 2022, at approximately 11:17 a.m., clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C confirmed residents were currently sharing the mechanical lift and confirmed the mechanical lift should be disinfected after resident use. The licensees' Cleaning of Shared Medical Equipment policy dated August 21, 2014, indicated the licensee would implement and maintain processes to ensure all reusable resident care equipment would routinely be cleaned, and when appropriate, disinfected, before and after reuse to include mechanical lifts. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 580		

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0 580	Continued From page 3 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 engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 17 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 8, 2022, at approximately 10:27 a.m., during the entrance conference with the Director of Operation (DO)-A and clinical nurse supervisor (CNS)-B, a request was made to review documentation of the licensee's quality management activities. CNS-B confirmed the licensee had not formalized or have documentation of ongoing quality management activities relevant to the size and services	0 580		

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0 580	Continued From page 4 provided by the assisted living. On August 11, 2022, at approximately 7:29 a.m., CNS-B confirmed she was unable to find any documentation of quality management actives for the past 12 months. The licensee's policy on quality management was requested and was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (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 ensure the provider established	0 660		

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0 660	Continued From page 5 and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included ensuring the completion of baseline TB screenings and two-step TST's (tuberculin skin test) or other evidence of TB screenings such as a blood test and TB training was were completed for three of three employees, clinical nurse supervisor (CNS)-B, licensed practical nurse (LPN)-C, and unlicensed personnel (ULP-I), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated June 28, 2021, indicated a low risk level. TB SCREENING CNS-B CNS-B had a hire date of June 14, 2022. CNS-B's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated June 29, 2022, indicated CNS-B completed the first step TST on June 29, 2022, and had not completed the TST second test as required. LPN-C LPN-C had a hire date of February 28, 2022. LPN-C's employee record included a Baseline TB	0 660		

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0 660	Continued From page 6 Screening Tool for HCWs dated June 29, 2022, indicated LPN-C completed the first step TST on June 29, 2022, and had not completed the TST second step as required. ULP-I ULP-I had a hire date of April 7, 2022, to provide direct care services to the license's residents. ULP-I's employee record included a Baseline TB Screening Tool for HCWs dated March 25, 2022, which indicated ULP-I had not received a TB skin test for TB blood test within 90 days of hire. TB EDUCATION CNS-B, LPN-C, and ULP-I's employee records lacked evidence TB education and training was completed as required. On August 11, 2022, at approximately 11:17 a.m., CNS-B and LPN-C confirmed the employee records noted above lacked the required completed TB blood test or two-step TST, TB education and training. The Minnesota Department of Health (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. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs."	0 660		

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0 660	Continued From page 7 The licensee's Tuberculosis and Staff policy dated July 25, 2021, indicated all staff would be screened and tested for tuberculosis and be educated regarding TB at time of hire. 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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 8 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 17 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 8, 2022, at approximately 10:27 a.m., a request was made to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. During the initial facility tour on August 8, 2022, at approximately 11:33 a.m., with clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-B, both Leonidas and Wacoutah units lacked signage posted or information regarding the licensee's emergency preparedness plan. CNS-B stated licensed practical nurse (LPN)-C was responsible for maintaining the licensee's emergency disaster plan and the Emergency Plan Manual was kept the office in the cupboard.	0 680		

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0 680	Continued From page 9 On August 11, 2022, at approximately 10:29 p.m., LPN-C confirmed she recently took over the licensee's emergency plan and had updated all of the contact numbers and resident information sheets. LPN-C confirmed the licensee lacked the following items as part of licensee's customized emergency preparedness plan: - post an emergency disaster plan prominently; and - EP training and testing program; (including documentation of training provided). The licensee's Disaster Planning and Emergency Preparedness policy dated July 24, 2021, indicated staff would be trained during orientation regarding the home care provider's disaster and emergency preparedness plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to monthly inspect the portable fire extinguishers, which was confirmed during facility tour. 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). The findings include: During on-site tour on August 9, 2022, between 10:45 a.m. and 12:45 p.m., the Director of Operations (DO)-A stated they did not have any documentation for the monthly Fire Extinguisher inspections. Survey staff requested fire extinguisher monthly inspection documentation, but the licensee could not provide the requested documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 11 (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 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	01470		

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01470	Continued From page 12 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 one of two employees, (unlicensed personnel (ULP)-I) received orientation to assisted living facility licensing to include all the required topics with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on August 8, 2022, at approximately 10:27 a.m., clinical nurse supervisor (CNS)-B confirmed licensed practical	01470		

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01470	Continued From page 13 nurse (LPN)-C was responsible for maintaining employee records and the licensee used EduCare (computer based training) for employee training and education. ULP-I had a hire date of April 7, 2022, to provide direct care services to the license's residents. ULP-I's employee record lacked the following required orientation content: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 8, 2022, at approximately ULP-I was observed administering R2's medications.	01470		

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01470	Continued From page 14 On August 11, 2022, at approximately 8:50 a.m., ULP-I stated she did not recall taking any of the required orientation content noted above. On August 11, 2022, at approximately 10:29 a.m., LPN-C confirmed she was unable to find documentation ULP-I's completed the required orientation to Assisted Living. LPN-C stated ULP-I started before LPN-C took over employee files and stated she was in the process of going through and organizing all employee files. The licensee's Orientation for Home Care Staff policy dated December 23, 2019, indicated all licensee's employees must complete the orientation to home care licensing requirements and regulations before providing home care services. The licensee lacked an updated policy to include the new Assisted Living Licensure requirements effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01540		

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01540	Continued From page 15 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two employees (licensed practical nurse (LPN)-C and unlicensed personnel (ULP)-I) received the dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 finding include: During entrance conference on August 8, 2022, at approximately 10:27 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee used EduCare (computer based training) for staff training and LPN-C was responsible for maintaining employee records. LPN-C LPN-C was hired on February 28, 2022, to	01540		

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01540	Continued From page 16 provide and supervise direct care services to the licensee's residents. LPN-C's employee record lacked evidence LPN-C completed eight (8) hours of the required dementia training within 120 hours of the employee's start date. ULP-I ULP-I had a hire date of April 7, 2022, to provide direct care services to the license's residents. ULP-I's employee record lacked evidence ULP-I completed eight (8) hours of the required dementia training within 80 hours of the employee's start date. On August 8, 2022, at approximately ULP-I was observed administering R2's medications. On August 11, 2022, at approximately 8:50 a.m., ULP-I confirmed she had not completed her dementia care education through EduCare. On August 11, 2022, at approximately 10:29 p.m., LPN-C confirmed herself and ULP-I's employee records lacked evidence LPN-C and ULP-I completed dementia care training as required. The licensee's ALDC Additional Dementia Staff Training policy dated August 1, 2021, indicated the licensee's staff who worked with residents with Alzheimer's disease and other dementias would have proper training for the tasks assigned. Training would be documented and would indicate staff knowledge and understanding of training. No further information was provided.	01540		

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01540	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments not to exceed 90 days for one of one resident (R2) with records reviewed.	01620		

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01620	Continued From page 18 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 entrance conference on August 8, 2022, at approximately 10:27 a.m., clinical nurse supervisor (CNS)-B confirmed resident assessments were completed by the RN on admission, 14 days after initiation of services, every 90 days, and upon a change in condition. R2's diagnoses included progressive multiple sclerosis (a disabling disease of the brain and spinal cord), urinary incontinence, dysphasia (difficulty swallowing), slurred speech, neurogenic bladder, hypertension (high blood pressure), and mild cognitive impairment. R2's unsigned Service Plan dated June 24, 2022, indicated R2 received services including medication management, treatment services, assistance with bathing, grooming, transferring, catheter care, laundry, and housekeeping. R2's record indicated the RN completed a comprehensive assessment on April 5, 2022, and a 90-day assessment August 1, 2022, which exceeded 90 days from the previous completed assessment by six (6) days. On August 10, 2022, at approximately 12:56 p.m., CNS-B verified R2's 90 day had not been	01620		

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	24664	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF MOUNTAIN IRO	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

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01620	Continued From page 19 completed timely within 90 days from R2's previous assessment as required. The licensee's Comprehensive Assessment policy dated October 31, 2021, indicated the RN would complete resident reassessments upon a change in condition and minimally at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two resident's (R2) service plan was authenticated with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included progressive multiple sclerosis (a disabling disease of the brain and spinal cord), urinary incontinence, dysphasia (difficulty swallowing), slurred speech, neurogenic bladder, hypertension (high blood pressure), and mild cognitive impairment. R2's Service Plan dated June 24, 2022, indicated R2 received services including medication management, treatment services, assistance with bathing, grooming, transferring, catheter care, laundry, and housekeeping. R2's Service Plan indicated it [service plan] was mailed on June 28, 2022, however, lacked authentication from the resident and/or resident's representative and the facility's representative. R2's record lacked documentation of follow up by the licensee to obtain R2's signed Service Plan.	01640		

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01640	Continued From page 21 On August 8, 2022, at approximately 1:30 p.m., unlicensed personnel (ULP)-I was observed administering R2 medication. On August 10, 2022, at 1:06 p.m., clinical nurse supervisor (CNS)-B confirmed R2's Service plan dated June 24, 2022, had not been signed by the resident or resident's representative. CNS-B stated she was unable to find documented evidence in R2's record of any follow up made by the licensee in obtaining R2's signed Service Plan that had been mailed June 28, 2022. The licensee's policy on service plans was requested and was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to document follow-up procedures when the licensee did not administer medications as prescribed for one of three (R3) residents with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3s record lacked documentation R3's provider was notified of missed medications. R3's start of services was February 9, 2022, and passed away April 8, 2022. R3's diagnoses included Lewy Body dementia (a progressive decline in mental abilities). R3's March 2022, Medication Administration Summary indicated R3 did not receive the following scheduled medications as prescribed: -trazadone (a medicine to treat depression and anxiety) 100 milligrams (mg) scheduled 8:00 p.m., dose was not given four (4) out of 24 opportunities; -Tylenol 500 mg scheduled 8:00 a.m., dose was not given three (3) out of 30 opportunities; -gabapentin (used to treat pain and restlessness) 100 mg scheduled 10:00 a.m. dose was not given 10 out of 23 opportunities;	01760		

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01760	Continued From page 23 -gabapentin 100 mg scheduled 2:00 p.m., dose was not given five (5) out of 23 opportunities; and -donepezil (used to treat mild to moderate dementia) 5 mg scheduled bedtime dose was not given 25 out of 30 opportunities. R3's March 2022, MAR included written notes that indicated the following: -R3's donepezil was not given on 21 occasions due to R3 being out of the medications; -R3's gabapentin was not given on 12 occasions due to R3 was sleeping. On August 8, 2022, at approximately 3:05 p.m., clinical nurse supervisor (CNS)-B verified R3's March 2022, MAR indicated missed medications noted above. CNS-B stated it was an expectation of staff to document why a medication was not given, to notify the nurse and the nurse should notify the provider if medications were not taken after three (3) days. CNS-B confirmed R3's record lacked documentation the reason why R3 was out of donepezil and if the provider was notified of R3's missed medications. The licensee's Medication Administration Documentation policy dated July 25, 2021, indicated the ULP will chart in each client's record medication administration record any problems with medication administration, including refusals. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12	01830		

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01830	Continued From page 24 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1's record lacked an annual renewal of prescriber orders for medications. During entrance conference on August 8, 2022, at approximately 10:27 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services for residents. R1's diagnoses included Alzheimer's disease, osteoarthritis, chronic obstructive pulmonary disease (COPD), and hypertension (high blood pressure). R1's Service Plan dated September 30, 2021, indicated R1 received medication management	01830		

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01830	Continued From page 25 services. R1's Individualized Medication Management Plan dated July 18, 2022, indicated staff would administer all medications for R1. R1's After Visit Summary dated June 17, 2022, included a list of R1's medications; however, lacked the prescriber's signature and documentation R1's medications were reviewed and renewed. R1's list of medications as of June 17, 2022 indicated the following medications: -aspirin 81 milligrams (mg) by mouth (po) daily; -CertaVite Senior take one tablet po daily for diabetes; -citalopram 10 mg one tablet po daily for anxiety disorder; -donepezil 10 mg two tables po at bedtime for dementia; -fish oil-omega three fatty acids 1000 mg take one capsule two times a day for high cholesterol; -memantine 10 mg one tablet po twice a day for dementia; -olanzapine 10 mg one tablet po at bedtime for bipolar; -pantoprazole 40 mg one tablet po twice a day for gastric reflux; -potassium chloride er 20 milliequivalents (meq) one tablet po for hypokalemia (low potassium); -psylliium 28.3% one packet po daily for constipation; and -slow-release iron 45 mg one tablet po for anemia. R1's July and August 2022, Medication Administration Record (MAR) listed medications as prescribed as noted above, times to administer, and staff initials to indicate the	01830		

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01830	Continued From page 26 medications had been given. On August 9, 2022, at approximately 9:02 a.m., unlicensed personnel (ULP)-F was observed administering R1's scheduled morning medications. On August 10, 2022, at approximately 8:30 a.m., clinical nurse supervisor CNS-B verified R1's most recent signed prescriber orders were from March 2021. CNS-B stated she had sent all resident orders to their providers for renewal of orders in July 2022, and had not received R1's signed returned orders. CNS-B stated she discovered she faxed R1's annual orders to the wrong provider. The licensee's Medication and Treatment Orders-Renewal dated July 25, 2021, indicated medication and treatment orders would be sent to the client's authorized prescriber for signatures at least every 12 months or more frequently if medications were new or changed and the signed orders would be placed in the client's permanent record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890		

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01890	Continued From page 27 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 bearing the original prescription label with legible information including the expiration date for time sensitive medications for three of three residents (R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 8, 2022, at approximately 11:33 a.m., the surveyor observed the medication cart on Wacoutah unit with clinical nurse supervisor (CNS)-B. CNS-B confirmed the following: R4 R4's opened Proventil (albuterol sulfate) inhaler (used to treat or prevent bronchiospasm), lacked a date the inhaler had been opened and when the inhaler would expire. R5 R5's opened bottle of Xalantan 0.005% ophthalmic suspension (medication to treat glaucoma) lacked the date the eye drop had been opened or would expire. On August 8, 2022, at approximately 12:00 p.m.,	01890		

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01890	Continued From page 28 the surveyor observed the medication cart on Leonidas unit with clinical nurse supervisor CNS-B. CNS-B confirmed the following: R6 R6's open albuterol sulfate (ProAir) inhaler (used to prevent and treat shortness of breath) had an original prescription label that was not legible and lacked the date the inhaler was opened or would expire. On August 8, 2022, at approximately 12:09 p.m., CNS-B was stated she was not aware inhalers and eye drops should be dated when opened to ensure the time sensitive medications were not used past the manufacturer's recommended used date. CNS-B confirmed R6's Albuterol inhaler's original prescription label was difficult to read and should be replaced. The manufacturer's instructions for Latanoprost ophthalmic solution revised August 2011, indicated once the bottle was opened, store at room temperature for up to six weeks. The manufacturer's instructions for albuterol sulfate (ProAir) inhaler revised June 2016, indicated as soon as the dose counter says 0 or after the expiration date on the PROAIR HFA packaging, whichever comes first. You should not keep using the inhaler after 200 sprays even though the canister may not be completely empty. The licensee's Storage of Medications policy dated December 24, 2019, indicated medications should be stored consistent with the manufacturer's recommendations. No further information was provided.	01890		

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01890	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01910		

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01910	Continued From page 30 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included Lewy Body Dementia (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function). R3's March 2022, Medication Administration Summary indicated R3 received the following scheduled medications: -trazadone (a medicine to treat depression and anxiety) 100 milligrams (mg) by mouth (po) every night; -Tylenol 500 mg two tablets po twice daily; -gabapentin (used to treat pain and restlessness) 100 mg one tablet twice a daily; -donepezil (used to treat mild to moderate dementia) 5 mg three tablets every night; -Miralax mix one capful in liquid twice a day for constipation; -amlodipine (to treat high blood pressure) 5 mg one tablet po once a day -bupropion (antidepressant) 300 mg po daily -I-Vite Protect (supplement) one tablet po daily; -aspirin 81 mg one tablet po daily; and -lisinopril (to treat high blood pressure) 20 mg po daily. R3's record contained a Discharge Transfer Summary that indicated R3 was admitted due to impaired cognitive and functional abilities related to dementia and had a discharge date of April 8, 2022; however, the summary lacked a disposition of medications to include:	01910		

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01910	Continued From page 31 - the medication name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition. On August 8, 2022, at approximately 3:05 p.m., clinical nurse supervisor (CNS)-B confirmed R3's record lacked the required content for the disposition of medications. The licensee's Disposal of Medication policy revised November 23, 2016, noted upon disposition, documentation in the record must include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

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01970	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R1) who received treatments managed by the provider. 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 entrance conference on August 8, 2022, at approximately 10:27 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided therapy and treatment services for residents. R1's diagnoses included Alzheimer's disease, osteoarthritis, chronic obstructive pulmonary disease (COPD), and hypertension (high blood pressure). R1's Service Plan dated September 30, 2021, indicated R1 received daily blood glucose monitoring. R1's July and August 2022, Medication Administration Summary listed daily blood glucose readings and staff initials to indicate R1's blood glucose was being monitored.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF MOUNTAIN IRO	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

(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
01970	Continued From page 33 On August 9, 2022, at approximately 9:02 a.m., unlicensed personnel (ULP)-F was observed monitoring R1's blood glucose with a reading of 110 milligrams per deciliter (mg/dl). R1's After Visit Summary dated June 17, 2022, included a list of R1's medications and blood glucose supplies; however, lacked the prescriber's signature and documentation R1's treatment orders were renewed. On August 10, 2022, at approximately 8:30 a.m., clinical nurse supervisor (CNS)-B verified R1's most recent signed prescriber orders were from March 2021. CNS-B stated she had sent all resident orders to their providers for renewal of medication and treatment/therapy orders in July 2022, and had not received R1's signed returned orders. CNS-B stated she discovered she faxed R1's annual orders to the wrong provider. The licensee's Medication and Treatment Orders-Renewal dated July 25, 2021, indicted medication and treatment orders would be sent to the client's authorized prescriber for signatures at least every 12 months or more frequently if medications were new or changed and the signed orders would be placed in the client's permanent record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF MOUNTAIN IRO	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

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02070	Continued From page 34 providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured dementia care units. This had the potential to affect all residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order on August 9, 2022. The findings include: The licensee failed to ensure one or more staff were always available during all shifts in each of the two separate secured dementia care units.	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24664	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF MOUNTAIN IRO	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

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02070	Continued From page 35 The licensee held an Assisted Living with Dementia Care license with a bed capacity of 26 residents and had a current census of 17 residents. During entrance conference on August 8, 2022, at approximately 10:27 a.m., clinical nurse supervisor (CNS)-B confirmed the facility's staffing schedule included two staff on day shift (6:30 am. to 2:30 p.m.), and one house coordinator, two staff on evening shift (2:30 p.m. to 10:30 p.m.) and two awake overnight staff (10:30 p.m., to 6:30 a.m.). Staff referred to unlicensed personnel (ULP). CNS-B's schedule work hours were typically Monday through Friday 9:00 a.m. to 5:00 p.m., and licensed practical nurse (LPN)-C Monday through Friday from 7:30 a.m. to 3:30 p.m. CNS-B confirmed the facility census was 17 residents and one resident in the hospital. CNS-B stated the licensee had one resident on Wacoutah unit and three residents on Leonidas unit that required a mechanical lift (a mechanical device used to assist with transferring). The physical layout of the facility consisted of two units (Leonidas and Wacoutah) connected by a link (large community room). Each unit consisted of a hallway, which measured approximately 139 feet in length. The link approximately 51 feet in length and was separated by fire exit doors, which required a key code to open. The Wacoutah unit had 10 resident rooms, occupied by eight residents. The Leonidas unit also had 10 resident rooms, occupied by eight residents. The Leonidas unit's secured exit door from the unit to the link had signage posted on both sides of the door indicating, "Please keep door closed at all times. Thank you."	02070		

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	24664	A. BUILDING: _____ B. WING _____	08/11/2022

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02070	Continued From page 36 On August 8, 2022, at approximately 1:41 p.m., R2 stated staff assisted her with transferring in and out of the bed and wheelchair with the use of a mechanical lift. R2 stated there were times she had to wait, especially in the evening because there were only two staff scheduled for both units and staff from the Leonidas unit had to the come to the Wacoutah unit to assist with the transfer. R2 stated on the overnight shift there was always only two staff scheduled, one for each unit. On August 9, 2022, at approximately 11:18 a.m., the surveyor observed ULP-D and ULP-E assist R2 transferring from the bed into the recliner chair with use of the mechanical lift. On August 9, 2022, at approximately 11:49 a.m., ULP-D and ULP-E confirmed there was only one staff scheduled in each of the units on the overnight shift and if a resident required assist of two staff, staff from one unit would have to leave their secured unit to assist in the other unit, leaving the secured unit unattended of staff. On August 9, 2022, at approximately 12:10 p.m., LPN-C confirmed staff were trained to use two staff when using any mechanical lift when transferring residents. LPN-C stated there were times when a resident required two staff to assist with transferring or repositioning and if there was not a float scheduled, or nursing was not available, staff would leave the unit unattended and go to the other unit to assist. On August 9.2022, at approximately 2:15 p.m., CNS-B confirmed two staff were needed when using a mechanical lift and if needed during the overnight shift, staff would have to leave their secured unit unattended to assist in the other unit.	02070		

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DIAMOND WILLOW OF MOUNTAIN IRO	8583 UNITY DRIVE MOUNTAIN IRON, MN 55768

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02070	Continued From page 37 On August 9, 2022, at approximately 2:22 p.m., the surveyor reviewed the staffing schedule from June 2022 to current date, with LPN-C. LPN-C stated she took over staff scheduling in April 2022, and followed the staffing plan to know how many staff were needed for each scheduled shift according to resident census. LPN-C confirmed she only scheduled two staff for the 10:30 p.m. to 6:30 a.m. overnight shift, one on staff in the Leonidas unit and one staff in the Wacoutah unit and has never scheduled a third staff to float between houses. The licensee's Staffing Plan dated February 14, 2022, indicated CNS would conduct and develop a staffing evaluation to identify appropriateness of staffing levels and adding emergency contact information to ensure that the facility is sufficiently staffed at all times in order to meet the needs of the residents and their safety. The licensee developed a staffing plan based on the number of residents. The licensee's staffing plan dated June 20, 2022, indicated between the hours of 10:30 p.m. and 6:30 a.m., there would be two staff on duty for an occupancy under 23 residents and two staff and a float for an occupancy of 23 residents and over. The licensee's undated Staffing policy indicated qualified employees would be scheduled to meet the needs [name of company] and its operations. The licensee's LIKO Sit-to stand-Lift policy dated February 9, 2022, indicated two staff were required to operate LIKO Sabina lift at all times unless the registered nurse (RN) had approved the resident was safe on lift with one staff. The policy further directed one staff could get the	02070		

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02070	Continued From page 38 resident ready and attach the sling (if the care plan indicated) but there must be two staff when the machine is in operations at all times. The licensee's Hoyer Lift policy dated July 25, 2022, indicated two staff were needed to be present when assisting a resident with transferring. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveryor's on-site obseravations and review by evaluation supervisor on August 11, 2022, however, non-compliance remains at a scope and severity of level three, widesrpread (I). TIME PERIOD FOR CORRECTION: Seven (7) days	02070		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02140	Continued From page 39 person(s) overseeing staff training in the care of individuals with dementia, clinical nurse supervisor (CNS)-B or licensed practical nurse (LPN)-C, had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 8, 2022, at approximately 10:27 a.m., CNS-B stated she and LPN-C were both in charge of overseeing the dementia care training for staff. CNS-B stated she did not have two years of work experience related to Alzheimer's disease, other dementias or in another related field. CNS-B stated she completed eight hours of "EduCare" (computer-based training) modules related to care of residents with dementia and was not aware of the specific required dementia training and competency of knowledge test approved by the Minnesota Department of Health (MDH). CNS-B's training transcript indicated CNS-B had completed the requisite number of required hours in dementia care. However, CNS-B's record lacked evidence CNS-B had demonstrated competency to be the person in charge of overseeing staff training.	02140		

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02140	Continued From page 40 On August 10, 2022, at approximately 12:33 p.m., LPN-C stated she was unable to provide completed dementia training course transcripts and confirmed she had not completed a competency or knowledge test in dementia care that included all of the requirements to be the person in charge of overseeing staff training. LPN-C stated she was unaware of the requirement. The licensee's ALDC Additional Dementia Staff Training policy dated August 1, 2021, indicated the person conducting such training would be qualified to train in the care of individuals with dementia. Qualifications would include: -two years of work experience related to Alzheimer's disease or other dementias, or in other health care, gerontology, or another related field, and; -has completed and passed training approved by MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based in observation, interview, and record review, the facility failed to ensure one of one resident (R2) was treated with dignity and respect	02350		

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02350	Continued From page 41 when R2's urinary drainage bag was exposed in common areas. 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: R2's diagnoses included progressive multiple sclerosis (a disabling disease of the brain and spinal cord), urinary incontinence, dysphasia (difficulty swallowing), slurred speech, neurogenic bladder, hypertension (high blood pressure), and mild cognitive impairment. R2's unsigned Service Plan dated June 24, 2022, indicated R2 received services including medication management, treatment services, assistance with bathing, grooming, transferring, catheter care, laundry, and housekeeping. On August 8, 2022, at approximately 1:41 p.m., R2's urinary drainage bag was not in a privacy bag and observed hanging on the side of R2's recliner chair. R2 stated her urinary drainage bag was never put in a privacy bag and staff never asked if her exposed urinary bag bothered her or others. R2 stated she would prefer her urinary drainage bag to be covered. On August 9, 2022, at approximately 11:42 a.m., unlicensed personnel (ULP)-E escorted R2 through the hallway and main common area to go	02350		

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02350	Continued From page 42 and sit outside. R2's urinary drainage bag was not in a privacy bag and observed hanging underneath R2's wheelchair. On August 10, 2022, at approximately 10:42 a.m., R2 was observed lying in her bed and R2's urinary drainage bag was hanging on R2's bed frame, not in a privacy bag and able to be seen from the hallway. On August 10, 2022, at approximately 10:45 a.m., ULP-E confirmed the licensee did not have privacy bags for the residents' urinary catheter drainage bags but had talked about getting some ordered. On August 10, 2022, at approximately 4:15 p.m., R2 was observed sitting outside in front of the building and R2's urinary drainage bag was observed hanging underneath R2's wheelchair seat. On August 11, 2022, at approximately 7:31 a.m., clinical nurse supervisor (CNS)-B confirmed urinary drainage bags should be put into privacy bags to maintain the resident's dignity. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *08/08/22*
Time: 08:04:12
Report: 1032221123

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Mountain Iro
8583 Unity Drive
Mountain Iron, MN55768
St. Louis County, 69

Establishment Info:
ID #: 0037730
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187411413
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
DOCUMENTS WERE RECENTLY SENT FOR CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.
Comply By: 09/14/22

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: BOTH DISHWASHERS
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: BOTH FREEZERS FROZEN
Violation Issued: No

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

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: TATER TOT HOTDISH
Violation Issued: No

Type: Full
Date: *08/08/22*
Time: 08:04:12
Report: 1032221123
Diamond Willow Of Mountain Iro

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler 2
Temperature: 39 Degrees Fahrenheit - Location: STRAWBERRY
Violation Issued: No

Process/Item: Upright Cooler 2
Temperature: 41 Degrees Fahrenheit - Location: GRAPE
Violation Issued: No

Process/Item: Upright Cooler 2
Temperature: 38 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

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

SPOKE WITH COOK, DEB MELL, ABOUT HANDWASHING, BAREHAND CONTACT WITH FOODS, FOOD TEMPERATURES, AND CERTIFIED FOOD PROTECTION MANAGER (CFPM) INFORMATION. SHE SAID THE KITCHEN MANAGER, AMY BOZICEVICH, RECENTLY SENT IN HER SERVE SAFE DOCUMENTS TO US FOR HER CERTIFICATE. I LOOKED UP THE CFPM TO SEE IF IT HAD PROCESSED AND WAS UNABLE TO LOCATE IT IN OUR SYSTEM.

THE UPRIGHT REFRIGERATOR HAD A THIN PLASTIC SHEET ON THE TOP SHELF TO KEEP CONDIMENTS FROM FALLING OVER. I RECOMMENDED REMOVING THIS SHEET TO ALLOW BETTER AIRFLOW, ALTHOUGH ALL INTERNAL TEMPERATURES WERE 41 DEGREES OR BELOW, AND THE STAFF AGREED TO REMOVE THE PLASTIC SHEET AND PUT SMALL CONDIMENTS IN A CONTAINER IN THE REFRIGERATOR TO ALLOW BETTER AIRFLOW.

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

I acknowledge receipt of the MDH inspection report number 1032221123 of 08/08/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
AMY BOZICEVICH
KITCHEN MANAGER

Signed:_____
Ben Kubes
Environmental Health Specialist
Duluth
ben.kubes@state.mn.us

Report #: 1032221123

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	1	Date	08/08/22
No. of Repeat RF/PHI Categories Out	0	Time In	08:04:12
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Diamond Willow Of Mountain Iro	8583 Unity Drive	Mountain Iron, MN	55768	2187411413

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037730		Full		

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		
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:** 08/09/22

Inspector (Signature) BG