



Protecting, Maintaining and Improving the Health of All Minnesotans

October 19, 2023

Licensee
Northwoods Villa Inc
1200 Gunn Road
Grand Rapids, MN 55744

RE: Project Number(s) SL34570015

Dear Licensee:

On October 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 16, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Jessie Chenze'.

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

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 7, 2023

Licensee
Northwoods Villa Inc
1200 Gunn Road
Grand Rapids, MN 55744

RE: Project Number(s) SL34570015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 16, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose 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 MDH 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 (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 survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34570015-0 On August 14, 2023, through August 16, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) active residents whom were receiving services under the Assisted Living license. An immediate correction order was identified on August 15, 2023, issued for SL34570015-0, tag identification 2310. On August 15, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that 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 14,	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 250	Continued From page 3 2023, at 10:00 a.m., housing manager (HM)-A stated the licensee's employees in charge of the facility were "not completely" familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent licensed assisted living director (LALD)-B, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorizing agent owner LALD-B on February 3, 2023. The licensee had an assisted living license reissued on April 1, 2023, with an expiration date of March 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a residents condition are identified, managed, and communicated to staff and other health care providers as appropriate; - medication management; - treatment management; - supervision of unlicensed personnel (ULP) performing delegated tasks; and	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 250	Continued From page 6 - orientation to and implementation of the assisted living bill of rights. As a result of this survey, the following orders were issued 0480, 0510, 0550, 0640, 0680, 0770, 0780, 0790, 0800, 0810, 0820, 1370, 1380, 1440, 1470, 1500, 1530, 1620, 1640, 1890, 1940, 1950, 1960, 2310, 2370, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 480	Continued From page 7 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 14, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel (ULP)-E, during wound care. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 510	Continued From page 8 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: On August 14, 2023, at 10:25 a.m., during the tour of the facility the surveyor observed a sign posted on R1's door indicating isolation precautions were active for R1 and staff were to utilize contact precautions. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E administer R1's morning medictions and proceed to a wound dressing change at the dining room breakfast table. ULP-E did not ask or offer to assist R1 to go to her room to perform the dressing change. ULP-E cleaned her hands with a hand sanitizer, donned (applied) a pair of disposable gloves and removed a soiled bandage from R1's left wrist at the dining room table. ULP-E looked at the wound, sat the soiled bandage on the table, removed a new bandage from her front pocket and reapplied the new bandage without changing gloves or washing/sanitizing hands. The newly applied bandage was undated. ULP-E exited the dining room after the bandage change and documented the medication administration. The surveyor asked if the dining room table had been sanitized with a disinfectant and ULP-E, ULP-D, nor licensed assisted living director (LALD)-B were able to verify if the table surface had been disinfected prior to co-residents joining R1 at the table and playing a board game. ULP-D stated, "I would assume so, I know she was looking for the	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 510	Continued From page 9 bleach wipes after I talked to her about it". On August 15, 2023, at 8:45 a.m., ULP-E stated she had forgotten to change gloves or wash hands between the removal of the used bandage and the placement of the new bandage. ULP-E stated she was "nervous". On August 15, 2023, at 10:00 a.m., the surveyor reviewed R1's progress notes and noted the following: - On August 3, 2023, at 2:45 p.m., a progress note was entered into R1's record by ULP-D : "The clinic called this morning to tell her [R1] that she has Methicillin-resistant Staphylococcus aureus (MRSA) (a type of bacteria that is resistant to several antibiotics, highly contagious and requires immediate medical attention) in her wrist and staff have begun standard precautions for that". On August 15, 2023, at 12:20 p.m., LALD-B stated, "the dressing change should never have happened at the table, that is not our protocol". The licensee's Infection Prevention and Control Program policy and Transmission-Based Precautions policy dated August 1, 2021, indicated the organization would follow the Center for Disease Control (CDC) Guidelines to include the disposal of contaminated materials, use of personal protective equipment and disinfecting equipment and surfaces. The Transmission-Based Precautions included: following CDC guidance, posting a notice on the door of the resident's room so that all personnel and visitors are aware of the isolation precautions, place necessary equipment and supplies that would be needed and assure an	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 510	Continued From page 10 adequate supply of antiseptic soap and paper towels were maintained in the room. Additionally, the policy indicated all staff would be in-serviced on appropriate transmission-based precautions. The Minnesota Department of Health (MDH) Infection Control Assessment and Response Program (ICAR) provide recommendations for managing communicable diseases in a document titled Wound Care Infection Prevention Recommendations for Long-Term Care Facilities dated November 30, 2022. The recommendations include the facility have a competency-based program for training all personnel who provide wound care, the facility monitor and documents adherence to wound care policies and procedures and when necessary implement Center for Disease Control (CDC) guidance to prevent the spread of multi-drug resistant organisms (MDROs). The CDC includes MRSA as a communicable MDRO in a document titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multi-drug resistant Organisms dated July 12, 2022, and explains MDROs are spread by direct and indirect contact with a resident or a residents environment and enhanced barrier precautions should be implemented when wound care is occurring. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 550	Continued From page 11 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the facility's grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 14, 2023, at 10:30 a.m., the surveyor toured the facility with housing manager (HM)-A. The surveyor requested to view the area containing the facility's grievance procedure. The	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 550	Continued From page 12 facility lacked the required grievance procedure posting to include contact information for the Office for Mental Health and Developmental Disabilities and the e-mail or phone contact information for the individual responsible for the facilities process. HM-A stated the above noted information was not posted. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content to include the 911 emergency number in common areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 640	Continued From page 13 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 14, 2023, at 10:30 a.m., the surveyor was observing the main areas of the facility with housing manager (HM)-A. The surveyor did not observe the 911 emergency number posted in the main areas or near a cordless telephone located on a countertop between the kitchen and dining room area. HM-A stated the cordless telephone could be used by staff, residents, or visitors. HM-A stated she was unaware of the requirement for the 911 emergency number to be posted near the cordless telephone and/or in common areas. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
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;	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 14 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license. 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 the entrance conference on August 14,	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 15 2023, at approximately 10:15 a.m., the surveyor requested to review the licensee's emergency preparedness plan. On August 14, 2023, at approximately 10:30 a.m., during a facility tour with housing manager (HM)-A, the surveyor observed no signage or information posted in the main entrance or elsewhere in the facility regarding the licensee's emergency plan. On August 15, 2023, at approximately 3:30 p.m., HM-A provided a red binder titled Emergency Plan. The binder included licensee's emergency preparedness and disaster plan October 5, 2018, however, lacked the following required content: - a description of the population served by the licensee; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - procedure for tracking staff and residents; - development of policies/procedures to address: - an evacuation plan customized for the facility; - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information. - a communication plan that addressed: - arrangements with other facilities; - names and contact information for staff, resident physicians, and other facilities; - contact information for federal, state, tribal, local EP staff, and ombudsman; - a method of sharing resident information and medical documentation; - a means to provide information regarding	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 16 the facility's needs, and its ability to provide assistance, including occupancy information; and -a method of sharing information from the licensee's emergency plan with residents and their families. On August 15, 2023, at approximately 4:30 p.m., HM-A confirmed licensee's emergency preparedness plan was not posted as required and lacked required information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by:	0 770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 770	Continued From page 17 Based on record review and interview, the licensee failed to test the well water within the last year. This had the potential to directly affect all residents and staff. 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: During an interview on August 15, 2023, at approximately 10:30 a.m., with owner maintenance (OM)-F and housing manager (HM)-A it was stated that the well water had not been tested within the last year for the building and that a new water well test needed to be performed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 780	Continued From page 18 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide working and interconnected smoke alarms in the resident rooms and corridors throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 15, 2023, at approximately 11:00 a.m. with owner	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 780	Continued From page 19 maintenance (OM)-F it was observed that smoke detectors were installed throughout the facility, but the smoke alarms in the east end corridor (new addition) and west end corridor do not operate upon activation of the test button. It was also observed the smoke alarms were not interconnected throughout the facility so that activation of any one smoke alarm activates all alarms throughout the facility. Smoke alarms are required to be maintained according to manufactures installation instructions and interconnected so activation of one alarm activates all alarms throughout the facility. This deficient finding was visually verified by OM-F at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
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	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 790	Continued From page 20 by: Based on observation and interview, the licensee failed to maintain portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 15, 2023, at approximately 11:30 a.m. with owner maintenance (OM)-F it was observed that fire extinguishers were present but not installed according to MN Statute 144G.45. At least one 2-A:10-B:C rated fire extinguisher located within 75' of travel throughout the facility and mounted not more than 5' to top of extinguisher is required to be installed and maintained according to MN Statute 144G.45. OM-F visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 21 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 15, 2023, at approximately 11:00 a.m. with owner maintenance (OM)-F it was observed that the attic access in the laundry room was covered with a piece of sheet foam. The attic access is part of the ceiling assembly as a fire stop and is required to be sealed with same material as the ceiling membrane. It was also observed that some of the numbers identifying resident rooms were not present or had been removed. Room numbers identifying	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 22 resident rooms are required to be maintained as part of the fire safety and evacuation plan and floor plan. It was also observed that two plumbing vents were bent over and broken on the north side of the roof. It was observed that metal trim was coming off on the roofs edge on the north and south side. The metal trim is required to be maintained to prevent water intrusion of the structure. It was observed the skylights had leaked at some point and caused damage to the interior ceiling membrane and trim; the skylight exterior flashing is in disrepair. The skylight flashing is required to be maintained according to product manufactures installation instructions. It was observed that refrigerators and freezers were plugged into one power tap in the room containing the sprinkler system riser in building #3 and #4. Refrigerators and freezers are required to be plugged directly into electrical outlets. The wood foundation water proofing was observed damaged, unprotected from the elements, and not flashed at the top to stop water from entering the assembly on the exterior south facing gable end wall. The wood foundation water proofing is required to be maintained and flashed in order to protect the structure from water intrusion. An exposed loose electrical wire with a taped splice and not in an electrical junction box was observed on the south exterior wall of the facility. Electrical wires are required to be protected from	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 23 the elements and damage and spliced in approved electrical junction boxes. An electrical outlet box trim cover was observed missing in the nurse office. Electrical outlet box trim covers are required to be maintained as approved at the time of construction to prevent accidental contact with live electrical wires. These deficient conditions were visually verified by OM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 24 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on August 15, 2023, at approximately 11:45 a.m. of documents provided by owner maintenance (OM)-F, licensed assisted living director (LALD)-B and housing manager (HM)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 25 Record review of the available documentation indicated that the licensee did not provide number and location of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. Record review of the available documentation indicated that the licensee included employee actions related to fire safety and evacuation but did not have specific employee actions for these specific facilities and buildings located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility fire safety and evacuation plan employee training	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 26 is required to be documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually. Record review of the available documentation indicated that evacuation drills had been conducted every third month of the year. Evacuation drills for staff are required to be conducted every other month and twice per year per shift and documented separately from employee training. All deficiencies were verified by OM-F, LALD-B and HM-A during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
0 820	Continued From page 27 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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 a facility tour on August 15, 2023, at approximately 11:30 a.m. with owner maintenance (OM)-F, it was observed the required exterior exit door was provided with a security chain installed at the head jamb, dead bolt, and a locking door handle. Required exit doors with a building occupancy of 10 or less are allowed to have a night latch, dead bolt or security chain but not more than one of these in addition to the locking door latch. It was also observed the interior door leading to the entry way of the exterior required exit door was provided with a privacy lock controlling access to the required exterior exit. This interior door is required to be openable from the interior	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
0 820	Continued From page 28 egress side without the use of keys or tools for access to the exterior required exit door. This deficient condition was verified by OM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01370	Continued From page 29 the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed in all required areas for two of two employees (unlicensed personnel (ULP)-D, ULP-E). 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: ULP-D ULP-D was hired on January 1, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D's employee file lacked documentation of training and competency evaluations for the	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01370	Continued From page 30 following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - preparation of modified diets as ordered by a licensed health professional; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the residents family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On August 14, 2023, at 4:26 p.m., the surveyor observed ULP-D provide transfer assistance services for R2 with a Sit-to-Stand mechanical lift (a transfer device utilizing a sling and hydraulic lift to raise an individual to a standing position). ULP-E ULP-E was hired on June 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's employee file lacked documentation of training and competency evaluations for the following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (iii) care and use of hearing aides; and	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01370	Continued From page 31 (iv) dressing and assisting with toileting. - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety; - preparation of modified diets as ordered by a licensed health professional; - awareness of confidentiality and privacy; and - awareness of commonly used health technology equipment and assistive devices. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E perform a wound dressing change for R1. On August 16, 2023, at 11:22 a.m., housing manager (HM)-A confirmed ULP-D and ULP-E's personnel records did not contain documentation ULP-D or ULP-E completed training in all required areas. HM-A stated, "we need to separate our training and train for assisted living". The licensee's Assisted Living Orientation - ULP Staff policy dated August 1, 2021, indicated each personnel file would include a record of all completed training and competency testing for unlicensed personnel. Additionally, the policy indicated all staff not a registered nursing assistant would receive additional training with a written or oral competency test and a skill demonstration. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01380	Continued From page 32 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for two of two (unlicensed personnel (ULP)-D, ULP-E) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-D ULP-D was hired on January 1, 2019, under the	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01380	Continued From page 33 comprehensive home care license and began providing assisted living services on August 1, 2021. On August 14, 2023, at 4:26 p.m., the surveyor observed ULP-D provide transfer assistance services for R2 with a Sit-to-Stand mechanical lift (a transfer device utilizing a sling and hydraulic lift to raise an individual to a standing position). ULP-D's employee record did not include documentation of training and competency evaluations for the following topics: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - range of motion and positioning. ULP-E ULP-E was hired on June 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E perform a wound dressing change for R1. ULP-E's employee record did not include documentation of training and competency evaluations for the following topics: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01380	Continued From page 34 observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - range of motion and positioning. On August 16, at 11:22 a.m., housing manager (HM)-A confirmed ULP-D and ULP-E's personnel files did not contain documentation ULP-D or ULP-E completed training in all required areas. HM-A stated, "we need to separate our training and train for assisted living". The licensee's Assisted Living Orientation - ULP Staff policy dated August 1, 2021, indicated each personnel file would include a record of all completed training and competency testing for unlicensed personnel. Additionally, the policy indicated all staff not a registered nursing assistant would receive additional training with a written or oral competency test and a skill demonstration. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01440	Continued From page 35 to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-E). 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: ULP-E was hired on June 14, 2021, under the comprehensive home care license and began	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01440	Continued From page 36 providing assisted living services on August 1, 2021. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E perform a wound dressing change for R1. ULP-E's employee record did not include documentation of a registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. On August 16, 2023, at 9:00 a.m., housing manager (HM)-A stated a 30-day supervision had not been completed on ULP-E. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working at the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 37 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 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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 38 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of three employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired on January 1, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 14, 2023, at 4:26 p.m., the surveyor observed ULP-D provide transfer assistance services for R2 with a Sit-to-Stand mechanical lift	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 39 (a transfer device utilizing a sling and hydraulic lift to raise an individual to a standing position). ULP-E ULP-E was hired on June 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E perform a wound dressing change for R1. ULP-D and ULP-E's employee orientation record did not include the following: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living service by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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 Deptment of Human Services, county-managed care advocates, or other relevant advocacy service; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 16, 2023, at 10:53 a.m., housing manager (HM)-A confirmed ULP-D and ULP-E had not completed the assisted living orientation as required. Additionally, HM-A stated they needed to review the training process, separate the training based on which building the staff	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 40 worked in and concentrate more on the assisted living training requirements for building 3. The licensee's Assisted Living Orientation - ULP Staff policy dated August 1, 2021, noted all newly hired unlicensed personnel would receive an orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days.	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 41 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01500	Continued From page 42 one of two employee (unlicensed personnel (ULP)-D). 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: ULP-D was hired on January 1, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 14, 2023, at 4:26 p.m., the surveyor observed ULP-D provide transfer assistance services for R2 with a Sit-to-Stand mechanical lift (a transfer device utilizing a sling and hydraulic lift to raise an individual to a standing position). ULP-D's employee record lacked evidence ULP-D successfully completed annual training as required to include: - a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 16, 2023, at 10:53 a.m., housing manager (HM)-A stated ULP-D had not completed the required annual training.	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 43 Additionally, HM-A stated they needed to review the training process, separate the training based on which building the staff worked in and concentrate more on the assisted living training requirements for building 3. The licensee's Personnel Records policy dated August 1, 2021, noted personnel records for each person would include a record of all required training, in-service education for all staff providing resident services and annual trainings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01530	Continued From page 44 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 three of three employee (unlicensed personnel (ULP)-D, ULP-E, clinical nurse supervisor (CNS)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-D ULP-D was hired on January 1, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 14, 2023, at 12:02 p.m., the surveyor observed ULP-D provide scheduled noon medications for R1. ULP-D's employee record indicated the employee	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01530	Continued From page 45 had completed a total of 0.75 hours of dementia training. ULP-D's employee record lacked a total of 8 hours of dementia training in the required topics to be completed within 160 hours of the employee's start date to include: - an explanation of Alzheimer's disease and other dementia; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On August 14, 2023, at 12:05 p.m., ULP-D stated she worked full time at the facility. ULP-E ULP-E was hired on June 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E perform a wound dressing change for R1. ULP-E's employee record indicated the employee had completed a total of one hour of dementia training to include communication skills . ULP-E's employee record lacked a total of seven hours of dementia training in the required topics to be completed within 160 hours of the employee's start date to include: - an explanation of Alzheimer's disease and other dementia; - assistance with activities of daily living; - problem solving with challenging behaviors; and - person-centered planning and service delivery. On August 15, 2023, at 8:30 a.m., ULP-E stated she worked full time at the facility.	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01530	Continued From page 46 CNS-C CNS-C was hired on June 1, 2023, to provide direct care services to residents and supervision to licensee's staff. On August 14, 2023, at 10:15 a.m., during the entrance conference, housing manager (HM)-A stated CNS-C was hired in June 2023 to provide oversight "one full day a week" at the facility, conduct all training and medication related tasks and to provide call support "24/7". CNS-C's employee record indicated CNS-C had not completed any of the required eight hours of dementia training within 120 working hours of the employee's start date. On August 16, 2023, at 11:00 a.m., HM-A provided a certificate to the surveyor indicating CNS-C had completed one hour of dementia training on August 15, 2023 (after survey entrance on August 14, 2023). On August 16, 2023, at 11:22 a.m., HM-A stated, "the dementia training, we just don't have it". The licensee's Assisted Living and Assisted Living with Memory Care Orientation - All Staff policy dated August 1, 2021, indicated newly hired staff would receive orientation and training on topics required for assisted living to include dementia training. The policy did not address the number of hours required or within the timeframe required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01620 SS=F	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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident reassessments, not to exceed 90 calendar days from the date of the last assessment utilizing the uniform assessment tool for three of three residents (R1, R2, R4) and failed to ensure the RN conducted ongoing resident assessments for two of three residents (R1, R4) with a change in condition.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01620	Continued From page 48 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: 90 DAY ASSESSMENTS R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan signed March 2, 2021, indicated R1 received assistance with medication administration, treatments, food preparation, housekeeping and laundry. On August 14, 2023, at 2:10 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's afternoon medications. R1's record included assessments labeled "annual" dated January 4, 2023, and April 19, 2023, respectively. There was 106 days between assessments, and no further assessments were included in the record, however, a 90 day assessment was due on July 18, 2023. R2 R2's diagnoses included schizoaffective disorder and seizure disorder. R2's Service Plan signed September 1, 2022, indicated R2 received assistance with medication administration, nail care, bathing, hygiene,	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01620	Continued From page 49 grooming, dressing, incontinence care, food preparation, housekeeping and laundry. On August 15, 2023, at 10:36 a.m., the surveyor observed ULP-D assist R2 from her bed to a wheelchair with the use of a Sit-to-Stand (mechanical lift device utilizing a sling and hydraulic lift to elevate an individual from a seated to a standing position). R2's record included an "annual" assessment dated January 4, 2023, and a comprehensive assessment dated January 26, 2023, however, no additional assessments were included in R2's record despite 90 day assessments being due April 26, 2023, and July 25, 2023. R4 R4's diagnoses included dementia and schizophrenia. R4's Service Plan signed July 12, 2023, indicated R4 received assistance with medication administration, treatments, bathing, hygiene, grooming, dressing, incontinence care, food preparation, housekeeping and laundry. On August 14, 2023, at 2:00 p.m., the surveyor observed ULP-D provide afternoon medications for R4. R4's record included an "annual" assessment dated January 4, 2023, and a 90 day assessment dated July 19, 2023. There was 195 days between assessments. CHANGE IN CONDITION R1 R1's record included notes entered into a communication log, written by staff, indicating the	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01620	Continued From page 50 following: - August 1, 2023, R1 was sent to the clinic for "suspicion of infection in her incision on left wrist". - August 2, 2023, "dressing on left wrist changed". - August 3, 2023, "clinic called and infection in wrist is MRSA (Methicillin-resistant Staphylococcus aureus, a staph infection that is difficult to treat because of resistance to some antibiotics). - August 4, 2023, "dressing change on left wrist". - August 6, 2023, "gauze changed this morning, still puffy and raised". - August 7, 2023, "upset over isolation. Gauze changed, looking good". - August 8, 2023, "staff encouraged her to come out of isolation". - August 10, 2023, "wrist continues to improve". - August 11, 2023, "bandage on left wrist changed a.m.". - August 13, 2023, "wrist is looking good". - August 14, 2023, "changed bandaid on left wrist". - August 15, 2023, "bandage on left wrist changed. - August 16, 2023, "left wrist bandage change, wound swollen, red, draining gunk/gooey." R1's record included After Visit Summaries (AVS) and the provider noted the following: - August 1, 2023, infected cyst of the skin, possible MRSA, start Bactrim DS twice daily for three (3) days for infection. Steri-strips applied to help reinforce closure of wound. Continue to monitor for worsening signs of infection. Gauze and paper tape daily change for next 3-4 days, steri-strips keep in place, may trim edges - ok to remove in 7 days or wait to see [nurse practioner name].	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01620	Continued From page 51 - August 3, 2023, physician office notified the facility, ULP-D, via phone of R1's MRSA infection to left wrist. - August 8, 2023, at 3:00 p.m., able to be around others once on antibiotic for 48-72 hours. If drainage, keep covered to avoid anyone touching. Change bandage to left wrist twice daily and as needed (PRN) if visibly soiled. Once wound healed/no longer drainage can stop bandages. Does not need to wear gloves or other protection to wrist. - August 16, 2023, R1 was seen at the clinic and physician noted: continue to wash twice daily with soapy water, keep covered with clean bandage, change as needed. May stay out of isolation if covered. May use ace wrap over bandage for protection. R1's record lacked a change in condition assessment. R4 R4's record included seven emergency room (ER) visits and Urgent Care visits between July 3, 2023 and July 28, 2023. After visit summaries (AVS) indicated the following dates and changes in condition: - July 3, 2023, an incident report indicated R1 had a fall in her bathroom resulting in a "bump on middle of back of head towards the top". R4 was seen in the emergency room with "pending" results for a concussion. - July 10, 2023, R4 was seen in the emergency room for elevated blood pressure. The physician noted, "she was very agitated in the emergency room. It would be important to have a discussion	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01620	Continued From page 52 with the family about goals of care for her going forward. She has a guardian who this can be discussed with". - July 14, 2023, at 3:20 p.m., R4 was seen at Urgent Care for elevated blood pressure (BP). ULP-E entered the following into R4's progress notes: "[R4's name] seemed wobbly and anxious this morning so BP taken. BP elevated, on-call and registered nurse (RN) notified". The attending physician noted the following dates and blood pressure readings: July 11, 2023, 151/91 and July 14, 2023, 162/68. The physician directed R4 be seen at the emergency room if blood pressure readings were above 180/90. Staff recorded elevated blood pressures on: - July 10, 2023 at 6:19 p.m. 202/90 (fall follow up); - July 16, 2023 at 6:45 p.m. 209/125; - July 21, 2023 at 6:27 p.m. 196/97; - July 23, 2023 at 6:18 p.m. 191/93; and - July 26, 2023 at 6:14 p.m. 180/92. - July 16, 2023, R4 was seen at the emergency room for hypertension (elevated blood pressure). The emergency room physician noted, " patient does continue to have blood pressure issues, recommend close follow-up with her primary care doctor". - July 17, 2023 at 10:40 a.m., R4 was seen at Urgent Care and the attending physician noted a fluid restriction was in place from May 16, 2023, and a change was made to Losartan. Losartan dosing was increased from 50 milligrams (mg) to 75 mg once daily for elevated blood pressure. - July 19, 2023, through July 20, 2023, R4 was hospitalized for uncontrolled hypertension and placed on a limited sodium diet of two (2) grams (g) daily.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01620	Continued From page 53 - July 21, 2023, R4 was seen at the emergency room for hypertension and agitation. The physician ordered a medication change: Losartan to 50 mg twice daily for hypertension and a follow up with physician in 12 to 24 hours or return to ER for a recheck. Blood pressure 176/105. - July 28, 2023 at 2:00 p.m., R4 was seen in the ER for hypertension. The physician ordered to discontinue Losartan 100 mg and start Losartan 75 mg at 8:00 a.m. and 50 mg at 5:00 p.m. for hypertension. R4's record lacked a change in condition assessment. On August 15, 2023, at 12:20 p.m., licensed assisted living director (LALD)-B and housing manager (HM)-A confirmed ongoing reassessments and change in condition assessments had not been completed as required. HM-A stated clinical nurse supervisor (CNS)-C had been to the facility on July 19, 2023, and assessed all three residents. LALD-B stated a previous RN would have been in charge of assessments, but had left employment December 31, 2022 and a new CNS-C, was hired in June 2023. Additionally, LALD-B stated the nurse should be called and notified, even if there were no changes, to be updated on appointments and the expectation is for assessments to be completed with changes in condition. The licensee's Assessment - Schedules policy dated January 1, 2019, indicated nurses would conduct assessments, monitoring, and reassessments at least every 90 days and changes in condition as indicated. The policy	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01620	Continued From page 54 indicated the immediate supervisor is responsible to ensure assessments of residents are complete according to regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 55 were updated for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan dated March 2, 2021, indicated R1 received assistance with medication administration, treatments, food preparation, housekeeping and laundry. On August 15, 2023, at 8:38 a.m., the surveyor observed unlicensed personnel (ULP)-E perform a wound dressing change for R1 and noted alarms to be activated on a sliding exit door in R1's room. On August 15, 2023, at 12:20 p.m., the surveyor asked ULP-D how long alarms have been active on R1's door and how long R1 has been monitored as an elopement risk. ULP-D stated, "some have been on longer than others. The newest alarm went on last summer (2022), the side door and patio door". R1's prescriber orders dated August 1, 2023, and August 8, 2023, included orders for daily dressing changes and wound care. R1's staff communication log dated August 1,	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 56 2023, through August 15, 2023, indicated staff were removing and applying a wound dressing to R1's left wrist. R1's service plan dated March 2, 2021, did not include daily wound care or safety/elopment monitoring. R2 R2's diagnoses included schizoaffective disorder and seizure disorder. R2's Service Plan dated September 1, 2022, indicated R2 received assistance with medication administration, nail care, bathing, hygiene, grooming, dressing, incontinence care, food preparation, housekeeping and laundry. On August 15, 2023, at 10:36 a.m., the surveyor observed ULP-D assist R2 from her bed to a wheelchair with the use of a Sit-to-Stand (mechanical lift device utilizing a sling and hydraulic lift to elevate an individual from a seated to a standing position) and provide ambulation assist to the dining room. On August 15, 2023, at 10:40 a.m., the surveyor asked ULP-D how long R2 had been using a mechanical lift, receiving ambulation and transfer assistance services. ULP-D stated, R2 started receiving hospice services December 20, 2022, and stated, "since then I think". R2's service plan dated September 1, 2022, did not include assistance with transfers, ambulation or the use of mechanical devices. On August 16, 2023, at 12:30 p.m., licensed assisted living director (LALD)-B acknowledged R1 and R2's service plan had not been revised or	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 57 updated to include current services provided. The licensee's Service Plan policy dated January 1, 2019, noted services would be delivered after an up-to-date service plan is signed by the registered nurse (RN) and the resident/resident's designated representative. The service plan must be revised, if needed, based on the results of required resident monitoring and/or reassessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01890	Continued From page 58 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: On August 14, 2023, at 10:45 a.m., the surveyor reviewed the locked medication cart with unlicensed personnel (ULP)-D. ULP-D observed and confirmed the following: R4's opened Flovent HFA 110 mcg (microgram)/ACT (actuation) aerosol inhaler did not have a label which indicated when the inhaler had been opened and when the inhaler would expire. R4's opened Ventolin HFA 90 mcg/ACT inhaler did not have a label which indicated when the inhaler had been opened and when the inhaler would expire. The manufacture expiration date indicated the inhaler had expired February 23, 2023. On August 14, 2023, at 10:45 a.m., ULP-D acknowledged the time sensitive medications were not labeled and stated "they should be labeled, that's our protocol." On August 15, 2023, at 12:35 p.m., licensed assisted living director (LALD)-B stated the expectation was all medications should be labeled with an opened and expiration date and staff are taught to use a label for all time sensitive medications. The manufacturer's instructions for Flovent HFA inhaler dated July 2013, directed to discard 60	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01890	Continued From page 59 days after opening. The manufacturer's instructions for Ventolin HFA inhaler dated July 2013, directed to discard 12 months after removing from foil pouch. The licensee's Inhalers policy dated January 1, 2019, indicated when inhalers were opened, staff were to label all inhalers with an open date and discard date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 60 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan with all required content for one of one resident (R1) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 14, 2023, at approximately 10:20 a.m., housing manager (HM)-A confirmed the licensee provided treatment and therapy services to residents. R1's diagnosis included multiple sclerosis (MS). R1's service plan dated March 2, 2021, unsigned by resident, indicated R1 received services to	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 61 include medication administration, a daily treatment, laundry, and housekeeping. On August 15, 2023, at 8:38 a.m., the surveyor observed unlicensed personnel (ULP)-E change a wound dressing for R1. R1's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On August 15, 2023, at 9:00 a.m., housing manager (HM)-A confirmed R1's Individualized Treatment and Therapy Plan lacked the above noted requirements and stated the registered nurse (RN) had added an individualized treatment plan for R1 into the computer the previous night at 7:00 p.m. (after survey entrance). The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated the RN would document the services the resident would receive on the resident's individualized treatment and therapy plan and the resident's treatment record. No further information was provided.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 62	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for one of one resident (R1) receiving wound care services. This practice resulted in a level two violation (a	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01950	Continued From page 63 violation that did not harm a client'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 diagnosis included multiple sclerosis (MS). R1's service plan, dated March 2, 2021, lacked inclusion of wound dressing changes. On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E perform a MRSA (a type of bacteria that is resistant to several antibiotics, highly contagious and requires immediate medical attention) infected wound dressing change. ULP-E cleaned her hands with a hand sanitizer, donned (applied) a pair of disposable gloves and removed a soiled bandage from R1's left wrist at the dining room table. ULP-E looked at the wound, set the soiled bandage on the table, removed a bandage from her front pocket and reapplied a new bandage without changing gloves between removal of the soiled bandage and application of a new bandage, washed or sanitized her hands or disinfected surfaces before or after the bandage change. ULP-E exited the dining room after the bandage change. On August 15, 2023, at 8:45 a.m., the surveyor asked how ULP-E knew to change the bandage without the task or instruction being on the list of tasks to complete. ULP-E stated the dressing change was not in the electronic treatment record (ETAR) and staff document a note by writing "bandage changed" in a communication log. The	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01950	Continued From page 64 surveyor asked ULP-E how the ULP's know when and how to change the dressing. ULP-E stated, "we just know to do it". The surveyor asked ULP-E who had provided the wound care dressing training for ULP-E. ULP-E stated, "the nurses". The surveyor asked for clarification of nurses and ULP-E provided two names [ULP-D and clinical nurse supervisor (CNS)-C]. ULP-E stated CNS-C had dropped off a pamphlet for staff to read and sign. On August 15, 2023, at 8:55 a.m., the surveyor observed the 5 page document CNS-C left for staff to read and sign. The document consisted of a Minnesota Department of Health (MDH) "learning about - patient guide", an explanation of what MRSA is and how it should be managed and a one page document titled "Changing Bandages - How do I change my bandages". ULP-E verified the documents reviewed were the training she had referred to. R1's physician orders dated August 1, 2023, included orders for "gauze and paper tape with daily change next 3 - 4 days (left wrist). Steri strips keep in place - may trim edges, ok to remove in 7 days or wait to see advanced practical registered nurse (APRN)". Physician orders dated August 8, 2023, included order for "able to be around others once on antibiotics for 48-72 hours. If drainage, keep this covered to avoid anyone touching. Change bandage to left wrist twice daily and as needed if visibly soiled. Once wound healed/no longer drainage, can stop bandages. Do not need to wear gloves or other protection on wrist." R1's record lacked a treatment and therapy management plan with instructions regarding the application and removal of the wound dressing	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01950	Continued From page 65 and any specific instructions for ULPs. On August 15, 2023, at 9:00 a.m., housing manager (HM)-A confirmed there was no treatment management plan developed for R1's wound dressing changes, however, CNS-C had entered a task for the dressing changes the previous night at 7:00 p.m. (after survey entrance). The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated ULPs that provide assistance with treatment and therapy administration would be trained and competency tested by the RN on the following: - the complete procedure for checking the resident's treatment and therapy profile and any additional information; - administration of the treatment and therapy to the resident; - documentation, after assistance with treatment and therapy administration consistent with licensee's procedures for documenting in the medical administration record (MAR); - before performing the procedures, the RN has instructed the unlicensed personnel in the proper method to administer the treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedure; and - the RN has developed written, specific instructions for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01960	Continued From page 66	01960		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee lacked proper documentation of wound treatment effectiveness for one of one residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 diagnosis included multiple sclerosis (MS). R1's service plan dated March 2, 2021, unsigned by resident, indicated R1 received services to include medication administration, a daily treatment, laundry, and housekeeping.	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
01960	Continued From page 67 R1's physician orders dated August 1, 2023, included orders for "gauze and paper tape with daily change next 3 - 4 days (left wrist). Steri strips keep in place - may trim edges, ok to remove in 7 days or wait to see advanced practical registered nurse (APRN)". Physician orders dated August 8, 2023, included order for "able to be around others once on antibiotics for 48-72 hours. If drainage, keep this covered to avoid anyone touching. Change bandage to left wrist twice daily and as needed if visibly soiled. Once wound healed/no longer drainage, can stop bandages. Do not need to wear gloves or other protection on wrist." On August 15, 2023, at 8:38 a.m., the surveyor observed ULP-E change R1's wound dressing. On August 15, 2023, at 8:40 a.m., the surveyor asked ULP-E how staff know to monitor and document the dressing change. ULP-E stated, "we just know and we write in the communication log when we change the bandage". R1's record lacked an assessment to include wound care and the effectiveness of treatment. R1's record lacked a means for staff to document the task completion and effectiveness of wound care as prescribed by the physician. On August 15, 2023, at 12:40 p.m., LALD-B stated, "as soon as there is a concern or a return the after visit summary (AVS) would be available to the nurse." Additionally, LALD-A stated the expectation would be for residents to have assessments done and chart notes entered with changes in condition.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
01960	Continued From page 68 The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated August 1, 2021, indicated all treatments administered would be documented in the medical administration record (MAR) after assistance is provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of three residents (R1, R2, R4) with a hospital bedrail. 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).	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 69 This resulted in an immediate correciton order issued on August 15, 2023. The findings include: R1 R1's diagnosis included multiple sclerosis (MS). On August 14, 2023, at 10:33 a.m., the surveyor observed R1's hospital bed had one upper bedrail in the upright position on the right side of her bed. R1's Service Plan dated March 2, 2021, indicated R1 required assistance with medication administration, grooming, meal setup, housekeeping and laundry. R1's bedrail assessment dated June 21, 2023, indicated R1 had increased muscle weakness, decreased ability to sit up, displayed decreased bed mobility and had one bedrail on her bed to assist with bed mobility and positioning. R1's Restraint/Entrapment Assessment dated June 21, 2023, indicated R1 had a half bedrail on her bed. R1 was able to grab onto the bedrail and reposition self. The risks and benefits of having the bedrail had been verbally reviewed with the resident. R1's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones pertaining to the use of the device. R2 R2's diagnoses included schizoaffective disorder and seizure disorder.	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 70 On August 14, 2023, at 4:26 p.m., the surveyor observed R2 in her room, seated in a manual wheelchair. R2's bed was observed to be a hospital bed with bilateral quarter upper bedrails. The left side bedrail was in the raised position. R2's Service Plan dated September 1, 2022, indicated R2 required assistance with medication administration, dressing, grooming, toileting, hygiene assistance, bathing, food prep, housekeeping and laundry. R2's assessment dated January 26, 2023, indicated R2 had cognitive impairment, was incontinent, confused and impulsive. R2's record lacked a bedrail assessment, including measurements, purpose for use, and risks versus benefits discussion. R4 R4's diagnoses included obesity and diabetes mellitus type II. On August 15, 2023, at 7:42 a.m., the surveyor observed R4's hospital bed had one upper bedrail in the upright position on the left side of her bed. R4's Service Plan dated July 12, 2023, indicated R4 required assistance with medication administration, dressing, grooming, incontinence, meal setup, treatments, housekeeping and laundry. R4's bedrail assessment dated September 29, 2022, indicated R4 had a half bedrail on her bed to assist with bed mobility, positioning and transferring in and out of bed.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 71 R4's Restraint/Entrapment Assessment dated September 29, 2022, indicated R4 had a half bedrail on her bed. The risks and benefits of having the bedrail had been verbally reviewed with the resident. R4's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones pertaining to the use of the device. On August 15, 2023, at 7:20 a.m., licensed assisted living director (LALD)-B stated R4's assessments did not include a bedrail assessment. LALD-B confirmed R1 and R4's records lacked measurements and an assessment of the Food and Drug Administration (FDA) entrapment zones for bedrails. On August 15, 2023, at 2:20 p.m., LALD-B measured R1's bedrail. The bedrail measured 18.75 inches tall by 3.25 inches wide at the largest open area. The measurement between the mattress and the bedrail was 0.75 inches. On August 15, 2023, at 2:25 p.m., housing manager (HM)-A measured R2's bedrail with the surveyor present. The bedrail measured 18 inches tall by 4.25 inches wide at the largest open area. The measurement between the mattress and the bedrail was 2.25 inches. The measurement of the gap between the top of the bed and the bedrail was 0.75 inches. On August 15, 2023, at 2:29 p.m., HM-A measured R4's bedrail with the surveyor present. The bedrail measured 17.75 inches tall by 3.25 inches wide at the largest open area. The measurement between the mattress and the	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 72 bedrail was 2.25 inches. The measurement of the gap between the top of the bed and the bedrail was 1.75 inches. The licensee's Siderails policy dated January 1, 2019, indicated the provider would assess the use, educate the resident, and when appropriate, the responsible person regarding the risks and benefits of siderails, and would verify the siderail in use was of a safe design and utilized consistent with manufacture directions, measurements and educate the resident and/or representative on the risk of entrapment, including injury and death. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 20, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 73 uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor on August 14, 2023, however, non-compliance remains at a scope and level of three, widespread (I).	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
02370	Continued From page 74	02370			
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of three residents (R1, R2, R4) had the right to enter and leave the facility as they chose. 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: The licensee held an Assisted Living license for a resident capacity of six. The facility was a single building which required staff to deactivate alarms at each door prior to exiting. Each exit door was secured with a motion alarm that alerted loudly when the door opened. During the entrance conference on August 4, 2023, at 10:00 a.m., housing manager (HM)-A stated all residents received the Minnesota Assisted Living Bill of Rights upon admission.	02370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
02370	Continued From page 75 R1 R1 was admitted for services on February 7, 2021, under the comprehensive home care license and continued to receive services under the assisted living license after August 1, 2021. R1's diagnosis included multiple sclerosis (MS). R1's service plan signed March 2, 2021, indicated R1 received assistance with medication administration, treatments, food preparation, housekeeping and laundry. R1's comprehensive assessment dated July 19, 2023, indicated R1 had severe cognitive impairment, however, also indicated R1 had no history of elopement, was not hostile or aggressive, and did not wander. R1 did not have the ability to come and go freely from the building. R2 R2 was admitted for services on July 28, 2021, under the comprehensive home care license and continued to receive services under the assisted living license after August 1, 2021. R2's diagnoses included schizoaffective disorder and seizure disorder. R2's Service Plan signed September 1, 2022, indicated R2 received assistance with medication administration, nail care, bathing, hygiene, grooming, dressing, incontinence care, food preparation, housekeeping and laundry. R2's comprehensive assessment dated January 26, 2023, indicated R2 had memory loss, confused and impulsive at times, wanders at	02370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
02370	Continued From page 76 times and needed a secured environment. The same comprehensive assessment indicated R2 did not have a history or risk for elopement. R2 did not have the ability to come and go freely from the building. R4 R4 was admitted for services on April 29, 2020, under the comprehensive home care license and continued to receive services under the assisted living license after August 1, 2021. R4's diagnoses included dementia and schizophrenia. R4's Service Plan signed July 12, 2023, indicated R4 received assistance with medication administration, treatments, bathing, hygiene, grooming, dressing, incontinence care, food preparation, housekeeping and laundry. R4's comprehensive assessment dated July 19, 2023, indicated R4 had cognitive impairment, poor decision making skills, had been hostile/aggressive in the past and was at risk for elopement. R4 did not have the ability to come and go freely from the building. On August 14, 2023, at 10:23 a.m., the surveyor toured the campus with housing manager (HM)-A. A screened porch door, a sliding glass door which provided entry to the porch, a front exit door which provided entry to the screened porch and a sliding glass door which exits R1's bedroom had motion alerting alarms attached to the doors. The surveyor asked if there were any residents allowed to exit the building	02370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
02370	Continued From page 77 independently and HM-A stated, "no, because of fall risks". On August 15, 2023, at 12:35 p.m., the surveyor asked unlicensed personnel (ULP)-D which residents were allowed outside without staff, ULP-D stated, "noone is allowed outside without staff with them because of the fall risk". The surveyor asked if other interventions had been put in place and licensed assisted living director (LALD)-B stated "sometimes every 15 minute safety checks, depending on the mental health scenario at the time". The documented safety checks were not available for review. The licensee's Bill of Rights policy dated January 1, 2019, indicated it was the policy of the licensee to protect the rights of their residents. Prior to the initiation of services to a resident, the licensee would provide the resident or the residents representative a written copy of the Minnesota Home Care Bill of Rights. On August 14, 2023, at 1:40 p.m., LALD-B stated the licensee had the correct Minnesota Bill of Rights available for residents and provided the surveyor a copy of the Combined Federal and State Home Care Bill of Rights for Assisted Living Clients dated November 2019. Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area. The Minnesota Bill of Rights for Assisted Living	02370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744		
(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
02370	Continued From page 78 Residents dated August 2022, under the Right to come and go freely, indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02370		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	03090		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER NORTHWOODS VILLA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 GUNN ROAD GRAND RAPIDS, MN 55744			
(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
03090	Continued From page 79 the residents). The findings include: On August 14, 2023, at 10:00 a.m., the Minnesota Department of Health surveyor entered the facility. A sign was posted on the left side of the main entry door of the facility indicating "Warning security cameras in use". On August 14, 2023, at 10:30 a.m., housing manager (HM)-A stated there was one active video camera located in the main area of the facility. HM-A stated she was unaware of the specific language that was required to be posted regarding electronic monitoring devices and stated they would "put up a new sign". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			



MINNESOTA DEPARTMENT OF HEALTH
Food, Pool, & Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 08/14/23
Time: 12:07:59
Report: 7939231136

Food and Beverage Establishment Inspection Report

Page 1

Location:

Northwoods Villa Inc
1200 Gunn Road
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:

ID #: 0037874
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183271919
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

NUMEROUS ITEMS IN THE FRONT FRIDGE WERE BEING HELD AT 48F AND TOSSED OUT.

Comply By: 08/14/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = >400PPM at Degrees Fahrenheit
Location: SPARY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: PORK
Temperature: 48 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: Yes

Process/Item: TUNA SALAD
Temperature: 33 Degrees Fahrenheit - Location: BACK ROOM FRIDGE
Violation Issued: No

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

DISCUSSION

PROPER COLD HOLDING TEMPERATURE - 41F OR BELOW

DISHWASHER TEMPERATURE AND PROPER SANITIZING OF DISHES TEST STICKERS LEFT

Type: Full
Date: 08/14/23
Time: 12:07:59
Report: 7939231136
Northwoods Villa Inc

Food and Beverage Establishment Inspection Report

Page 2

WITH WANDA

WMETZER40@GMAIL.COM

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH
inspection report number 7939231136 of 08/14/23.

Certified Food Protection Manager: _____

Certification Number: APPLIED Expires: / /

Signed: _____

WANDA METZER
CFPM

Signed: _____

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us