Electronically Delivered

April 10, 2023

Licensee
Diamond Willow Of Little Falls
1401 5th Avenue Northeast
Little Falls, MN 56345

RE: Project Number(s) SL25706015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 21, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

correction order receipt date.

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

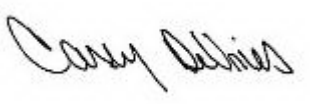
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LITTLE FALLS	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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: SL25706015-0 On March 20, 2023, through March 21, 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 20 residents, all of whom received services under the provider's Assisted Living with Dementia license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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: During the entrance conference on March 20, 2023, at 9:30 a.m., licensed practical nurse/licensed assisted living director (LPN/LALD)-B stated LPN/LALD-B was the current LALD for the facility. On March 20, 2023, at 11:56 a.m., the evaluator reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LPN/LALD-B. The BELTSS website identified LPN/LALD-B as a licensed assisted living director (effective September 3, 2021; expires October 31,2023). The website identified LPN/LALD-B as the Director of Record for the licensee had expired as of date for December 8, 2022, (effective September 3, 2021; expires December	0 110		

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0 110	Continued From page 2 8, 2022), LPN/LALD-B stated the BELTSS website had not been updated to identify him as the Director of Record. LPN/LALD-B stated he was unaware this needed to be done. On March 21, 2023, upon exit review, at 1:30 p.m., agent (A)-F stated LPN/LALD-B was renewed under the licensee's old HFID and was not renewed under the current HFID. A-F stated LPN/LALD-B has been renewed under the current HFID. The licensee's policy 1.58 Delegation of Authority for Licensed Living Director with Shared Director License dated November 25, 2022, indicated the licensee would identify and select a LALD or (assisted living director in residence) ALDIR within five days of the facility becoming void of a LALD. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 480		

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0 480	Continued From page 3 Food Code. This had the potential to affect all 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 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 March 20, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed	0 485		

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0 485	Continued From page 4 in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Contract, dated February 1, 2022, page 4, included: "The Community will provide three (3) nutritionally well-balanced meals per day, served in the community Dining Room(s). Snacks will also be available to the resident." The licensee's uniform disclosure of assisted living services and amenities (UDALSA) dated February 1, 2023, page 34, included: "Three meals available, plus snacks required." On March 20, 2023, at 11:56 a.m., licensed practical nurse/licensed assisted living director	0 485		

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0 485	Continued From page 5 (LPN/LALD)-B stated the contract listed above was used for all residents who resided in the facility. LPN/LALD-B stated three meals per day were included in the resident's monthly fee and there was not an option for a resident to opt out of a meal or all meals. On March 20, 2023, at 1:09 p.m., clinical nurse supervisor (CNS)-A stated there was one set rate for all three meals and there was not an option for a resident to opt out of all three meals. On March 21, 2023, at 1:30 p.m., agent (A)-F stated, " I'm not sure how we would separate the meals out, this is memory care. We wouldn't be able to track if the residents were eating a nutritional meal or not". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan with the required content for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 R2's diagnoses included cerebral infarction (stroke) affecting left side and hemiplegia. R2's service plan dated February 27, 2023, indicated R2 received services including transfer assist, repositioning, oral care, medication administration, housekeeping and laundry. On March 20, 2023, at 11:25 a.m., the evaluator observed unlicensed personnel (ULP)-C and ULP-D transfer R2 from a Broda chair (an ergonomically designed mobile wheelchair used to reduce pressure areas) using a Hoyer (a mechanical lift with sling) into R2's hospital bed. The evaluator observed ULP-C and ULP-D provide incontinence cares and transfer R2 back into the Broda chair. R2's Individual Abuse Prevention Plan (IAPP)	0 630		

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0 630	Continued From page 7 dated February 27, 2023, indicated R2 required total assistance from two staff for activities of daily living (ADLs) and R2 was at risk to be abused. R2's individual abuse prevention plan did not include: - the resident's risk of abusing other vulnerable adults, and; - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R4 R4's diagnoses included dementia and transient cerebral ischemia (stroke). R4's service plan dated February 13, 2023, indicated R4 received services including mobility assistance, dressing, grooming, eating assistance, transfer, toileting, medication administration, bathing assistance, housekeeping and laundry. R4's Individual Abuse Prevention Plan dated February 27, 2023, indicated R4 was dependent on staff to assist with ADLs daily and R4 was at risk to be abused. R4's individual abuse prevention plan did not include: - the resident's risk of abusing other vulnerable adults, and; - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On March 21, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-A confirmed R2 and R4's IAPP did not address the above noted areas of risk or	0 630		

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0 630	Continued From page 8 include statements of specific measures to be taken to minimize risks. CNS-A stated, "I may have missed those areas when I completed the assessments in Rtasks" (electronic record system). The Licensee's Nursing Assessment Individual Abuse Prevention Plans policy revised and updated February 28, 2022, indicated licensee would ensure a nursing assessment was completed by a registered nurse prior to the delivery of nursing services. The policy did not directly address individual abuse prevention plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 9 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included required content of annual performance reviews for two of four staff (clinical nurse supervisor (CNS)-A and licensed practical nurse/licensed assisted living director (LPN/LALD)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: CNS-A CNS-A was hired July 21, 2021. CNS- A's employee record lacked evidence or documentation of annual performance reviews that identified areas of improvement needed and training needs for the year of 2022. Review of records indicated CNS-A actively	0 650		

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0 650	Continued From page 10 provided assisted living services to the licensee's current residents. LPN/LALD-B LPN/LALD-B was hired under the comprehensive home care license on March 3, 2008, and began providing assisted living services on August 1, 2021. LPN/LALD-B's employee record lacked evidence or documentation of annual performance reviews that identified areas of improvement needed and training needs for the year of 2022. LPN/LALD-B employee record contained an annual performance review dated April 14, 2021. The record lacked evidence or documentation of annual performance reviews that identified areas of improvement needed and training needs for the years of 2022. On March 20, 2023, at 1:09 p.m., CNS-A stated the director of nursing has not completed her annual performance review. On March 20, 2023, at 1:39 p.m., LPN/LALD-B stated the licensee did not have an annual performance review last year. The licensee's 2.02 Personal Files/Employee Record dated January 31, 2019, indicated files would contain required documents by the Minnesota Department of Health Regulations including documentation of annual performance review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 21, 2023, at approximately 1:00 p.m. with the Director of Maintenance (M)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, M-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LITTLE FALLS	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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 13 included in the fire safety and evacuation plan. During interview, M-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, M-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, M-E stated the licensee did not have any documented training or a policy on training employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, M-E stated that the facility did not have documentation or a policy on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LITTLE FALLS	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

(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 14 every other month as required by statute. Provided documentation indicated that drills were completed on 1.4.23, 1.25.23, and 10.6.22. Fire drill policy indicated drills were to be done quarterly with a minimum of one drill annually per shift. During interview, M-E verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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	25706	A. BUILDING: _____ B. WING _____	03/21/2023

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01620	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 14 for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included cerebral infarction (stroke) affecting left side and hemiplegia. R2's service plan dated February 27, 2023, indicated R2 received services including transfer assist, repositioning, oral care, medication administration, housekeeping and laundry. On March 20, 2023, at 11:25 a.m., the evaluator observed unlicensed personnel (ULP)-C and ULP-D transfer R2 from a Broda chair (an ergonomically designed mobile wheelchair used to reduce pressure areas) using a Hoyer (a mechanical lift with sling) into R2's hospital bed. The evaluator observed ULP-C and ULP-D provide incontinence cares and transfer R2 back into the Broda chair. R2's record included an admission assessment	01620		

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	25706	A. BUILDING: _____ B. WING _____	03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW OF LITTLE FALLS	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

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01620	Continued From page 16 dated February 27, 2023. R2's record lacked a 14-day assessment due on March 13, 2023. On March 21, 2023, at 11:40 a.m., the evaluator reviewed R2's electronic medical record with clinical nurse supervisor (CNS)-A and verified a 14-day assessment had not been completed for R2 as required. CNS-A was aware R2's assessment was overdue and stated, "I'm doing that today". The licensee's Nursing Assessment Ongoing policy updated and revised September 5, 2022, indicated licensee would ensure that a nursing assessment was completed by a registered nurse prior to the delivery of nursing services and the execution of a service agreement. The policy did not address ongoing assessments that are required by assisted living regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730		

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	25706	A. BUILDING: _____ B. WING _____	03/21/2023

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DIAMOND WILLOW OF LITTLE FALLS	1401 5TH AVENUE NE LITTLE FALLS, MN 56345

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01730	Continued From page 17 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25706	A. BUILDING: _____ B. WING _____	03/21/2023

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01730	Continued From page 18	01730		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

During the entrance conference on March 20, 2023, at approximately 9:45 a.m., clinical nurse supervisor (CNS)-A confirmed the licensee provided medication management services to the residents in the facility.

R1's diagnoses included dementia, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

R1's service plan dated January 18, 2023, indicated R1 received services to include medication administration five times daily.

R1's electronic medication administration record (EMAR) dated March 2023 included the following medications: a mild pain reliever, one stomach acid reducer, an anti-depressant, two cognitive enhancing medications, two vitamin supplements, a heart rate stabilizer, a mood stabilizer, one eye drop, one diuretic, one blood thinner and one inhaler.

On March 20, 2023, at 11:53 a.m., the evaluator observed unlicensed personnel (ULP)-D provide medication administration to R1. ULP-D verified and removed acetaminophen 325 milligram (mg) (2 tabs) and buspirone, one five (5) mg tab from the foil backed bubble pack into a paper medication cup. ULP-D crushed the medication

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01730	Continued From page 19	01730		

with a medication crushing device, added the medications into another small plastic medication cup containing three tablespoons of applesauce. ULP-D mixed the medication into the applesauce and spoon fed the medications to R1.

On March 20, 2023, at 1:30 p.m., the evaluator asked ULP-D how long medications have been administered to R1 crushed and spoon fed. ULP-D stated, "since she got here". R1 admitted for services on January 18, 2023.

R1's individual medication management plan updated February 1, 2023, indicated R1 took medications whole with water.

R1's medication management record did not include the following:
- a statement describing the medication management services that would be provided;
- documentation of specific resident instructions relating to the administration of medications; and
- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

On March 21, 2023, at approximately 11:40 a.m., CNS-A confirmed R1's individualized medication management plan did not match the medication services provided and lacked required content noted above. CNS-A stated, "I'm updating that now".

The licensee's Medication Administration and Crushing Meds policy updated September 4, 2022, provided direction for the process of administering crushed medications, however, did

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01730	Continued From page 20 not address the requirements of an individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *03/20/23*
Time: 11:23:41
Report: 1017231066

Food and Beverage Establishment Inspection Report

Location:
Diamond Willow Of Little Falls
1401 5th Avenue Ne
Little Falls, MN56345
Morrison County, 49

Establishment Info:
ID #: 0038308
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206162845
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.

3-800 Highly Susceptible Populations

3-801.11C ** Priority 1 **

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

KAYLEE (CFPM) STATED THAT BREAKFAST EGGS ARE SOFT POACHED AND SERVED UNDER COOKED (UNKNOWN TEMPERATURE). EGGS WERE NOT PASTEURIZED, COOK EGGS TO PROPER TEMPERATURE. SEE FACT SHEET ATTACHED WITH REPORT.

Comply By: 03/20/23

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: DISH MACHINE LINDBERG SIDE
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE STAR SIDE
Violation Issued: No

Acid: = 1130 PP at Degrees Fahrenheit
Location: SPRAY BOTTLE PRE-MIXED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit - Location: LETTUCE LOCATED IN DRY STORAGE FRIDGE
Violation Issued: No

Type: Full
Date: *03/20/23*
Time: 11:23:41
Report: 1017231066
Diamond Willow Of Little Falls

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: CHEESE LOCATED IN UPRIGHT COOLER LINDBERGH SIDE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 191 Degrees Fahrenheit - Location: CHICKEN LOCATED IN POT ON STOVE STARLITE SIDE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CHEESE LOCATED IN UPRIGHT COOLER STARLITE SIDE
Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

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 1017231066 of 03/20/23.

Certified Food Protection Manager: KAYLEE R. SELINSKI

Certification Number: FM 113987 Expires: 11/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231066

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	03/20/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:23:41
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Diamond Willow Of Little Falls	1401 5th Avenue Ne	Little Falls, MN	56345	3206162845

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0038308		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/21/23

Inspector (Signature)