



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 10, 2023

Licensee
Diamond Willow Of Alexandria
803 Victor Street
Alexandria, MN 56308

RE: Project Number(s) SL26046015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 20, 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:

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

Free from Maltreatment reconsideration requests should be addressed to:

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: SL26046015-0</p> <p>On January 17, 2023, through January 20, 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 16 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 1</p> <p>(13) offer to provide or make available at least the following services to residents:</p> <p>(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:</p> <p>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>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 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 January 18, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 490 0 490 SS=F	Continued From page 2 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities, based upon individual and group interests, physical, mental, and psychosocial needs for three of three residents (R1, R2, R5) in the Lake Agnes Suites area of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 490 0 490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 490	<p>Continued From page 3</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on January 17, 2023, at 10:28 a.m., registered nurse (RN)-A stated the licensee offered activities, but was unsure who was responsible for them. RN-A disclosed she had only been working for the licensee for a couple of months and was still learning the daily routines. RN-A provided a copy of scheduled activities for January 2023.</p> <p>The January 2023 activity calendar indicated the following activities were scheduled during the survey: January 17: church, daily chronicles, trivia and bingo; January 18: balloon toss, daily chronicles, trivia, movie; and January 19: reminiscing, daily chronicles, trivia and crafts. The scheduled did not include timed when activities were to take place.</p> <p>During observations on January 17, 2023, (between 10:00 a.m. and 5:00 p.m.), January 18, 2023, (between 6:15 a.m. and 5:00 p.m.), and January 19, 2023, (between 8:15 a.m. and 5:00 p.m.) the evaluator observed none of the scheduled activities were offered to the residents in the Lake Agnes Suites area.</p> <p>R1 R1's activity plan dated December 8, 2022, indicated R1's interests included music, nature, bingo, visiting and cars. The plan indicated R1</p>	0 490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 490	<p>Continued From page 4</p> <p>participated in wellness activities of choice without help, was non-ambulatory and staff assisted R1 as needed in wheelchair.</p> <p>On January 17, 2023, at 12:06 p.m., the evaluator observed R1 seated in his wheelchair and noted the TV was on in his room. R1 wheeled himself from his room into the large day room area that connected the two main sections of the facility. R1 stated the licensee had not been providing activities recently and added, "I've heard staff do not have time to do activities." R1 stated residents can watch TV, "and I do a lot of that in my room, but have not had consistent activities, I would say for about 6 months."</p> <p>R2 R2's activity plan, dated January 9, 2023, indicated R2's interests included music and family and, in the past, R2 loved to sing. The plan indicated R2's spouse will bring her to music activities and also plays music for client [resident] daily. Additionally, the plan indicated R2's religion tradition, R2's ambulatory and communication status, and that staff were to assist with mobility per care plan.</p> <p>On January 17, 2023, at 2:26 p.m., family member (FM)-H stated his spouse (R2) had resided at the facility for many years. The evaluator asked about what activities were offered to which FM-H stated he had not seen much lately and that things stalled out during COVID. FM-H stated he no longer believed R2 was capable of doing any activities, but mentioned the licensee used to have regular bingo, some music entertainers and some activities for chair exercises. FM-H said other residents would no doubt like daily activities to pass the time.</p>	0 490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 490	<p>Continued From page 5</p> <p>R5 R5's activity plan dated November 30, 2022, indicated R5's past interests included life on the farm and family visits. The plan indicated R5 needed cueing, reminders and encouragement to participate in wellness activities, used a wheelchair for mobility and identified R5's religious tradition.</p> <p>On January 18, 2023, at 10:46 a.m., the evaluator observed R5 seated in an electric wheelchair and watching TV in her room. R5 said she really didn't do activities. R5 showed the evaluator the January activity calendar and said she's seen the list of activities, "but they don't go by it." R5 stated if they had music or a Catholic mass, "I'd go, it's just not offered."</p> <p>On January 18, 2023, at 2:15 p.m., unlicensed personnel (ULP)-D stated the staff were supposed to do activities but did not have the time and stated lately, an activity had been a rare occasion. ULP-D stated she had not read the daily chronicles to the residents as indicated on the schedule, and that many of the residents required more one-to-one activity. Regarding the lack of resident activities, ULP-D stated it was a matter of not having the time and needing to complete all the required nursing tasks.</p> <p>On January 18, 2023, at 5:40 p.m., ULP-F said the activities have been kind of slacking and that activities were something the household coordinators (HHC) used to help out with. ULP-F said they recently lost a HHC and the replacement staff was "brand new," with limited experience. ULP-F said it was difficult to get to activities started or supervised with limited staff. ULP-F said she often was the only one on this</p>	0 490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 490	<p>Continued From page 6</p> <p>side of the building, and when float staff comes on the unit, they use the time to get lifts, transfers, toileting completed, and narcotics signed out, which leaves no time for activities.</p> <p>On January 19, 2023, at 9:13 a.m., registered nurse (RN)-A said there should "absolutely" be activities for all, including various one-to-one activities, small groups, coffee, and socialization. RN-A stated she'd been awakened to what iss happening [at the facility] and said the unlicensed staff have a lot on their plates, with the expectation of providing cares, transfers, toileting, the housekeeping chores, passing medications. RN-A stated "I can see why" activities are not a priority and are on the bottom of their to-do list.</p> <p>On January 19, 2023, at 2:43 p.m., assistant regional director of operations/licensed assisted living director(ARDO/LALD)-B stated their expectation was activities should be planned every day. ARDO/LALD-B stated staffing is a struggle everywhere and with a full complement of staff, they would be able to meet expectations we have to provide activities for our residents.</p> <p>The licensee's Life Enrichment Programs, Activities & Outdoor Space policy, effective August 1, 2021, indicated the facility strives to provide valuable activities and life enrichment programs for resident's with Alzheimer's disease or other dementias. Further, a selection of daily, structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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 SS=D	<p>144G.41 Subd. 3 Infection control program</p> <p>(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.</p> <p>(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.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>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 four unlicensed personnel (ULP-K) during preparation of food and medication administration for two of five residents (R5, R8).</p> <p>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).</p> <p>The findings include:</p> <p>On January 18, 2023, at 7:47 a.m., the evaluator observed ULP-K and ULP-D during morning cares for R8. The ULPs moved R8 side to side in</p>	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 8</p> <p>his bed and ULP-K checked R8's incontinent brief, then positioned a lift sling under the resident. After the ULPs transferred R8 into the wheelchair, ULP-D made R8's bed, removed her gloves, washed her hands with soap and water in R8's bathroom and ULP-D exited the room. at 7:50 a.m.</p> <p>ULP-K remained in R8's room, donned a new pair of gloves, set up and administered oral medications for R8. ULP-K also prepared a nebulized medication for R8, adjusted the mask on R8, turned on the nebulizer, removed her gloves and discarded them into trash. ULP-K performed no hand hygiene and exited R8's room. ULP-K walked to the medication room, where she counted medications with another staff person. ULP-K exited the medication room, entered the kitchen area, and there the evaluator observed ULP-K pull a cell phone from her scrub top pocket, glanced at it, then returned the phone to her pocket. ULP-K performed no hand hygiene while in the kitchen. At 7:57 a.m., ULP-K abruptly left the kitchen, returned to R8's room to check on R8's nebulizer, then came back to the kitchen area when ULP-K washed her hands in the kitchen sink. At 7:59 a.m., ULP-K moved from the kitchen to the dining area, tied her hair up with a hair band, and talked with another resident seated at table, R5, and asked what she wanted for breakfast. Returning to the kitchen and without any hand hygiene after touching her hair, ULP-K pulled pans, plates, and silverware from the kitchen cupboards and drawers, then using a knife, placed some butter in the frying pan to prepare eggs for R5. Seeing no eggs in the refrigerator, ULP-K reached in her pocket for keys, left the kitchen and went to the storeroom, returning with a carton of eggs. ULP-K cracked an egg into a bowl, scrambled it, then poured it</p>	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 9</p> <p>into the frying pan. At 8:11 a.m., ULP-K left the kitchen area and asked R5 if she wanted toast with the egg. ULP-K then exited the kitchen/dining area and returned to R8's room. There, ULP-K removed the nebulizer, rinsed it off, set the parts on a towel and then wheeled R8, seated in his wheelchair, to the dining area. With no hand hygiene performed, ULP-K returned to the kitchen at 8:13 a.m., and appeared frustrated as the eggs were burned and began to remake R5's eggs. ULP-K started a new pan of eggs, then again reached into her pocket to get keys and left the kitchen to the food storage area and returned with a loaf of bread. Without performing hand hygiene, ULP-K opened the loaf of bread and placed two slices in the toaster. After the bread toasted, ULP-K donned a pair of gloves, buttered and jammed the bread, and served R5 eggs and toast. After R5's breakfast was served, ULP-K removed gloves and washed her hands with soap and water in the kitchen sink.</p> <p>On January 18, 2023, at 10:14 a.m., the evaluator asked ULP-K about hand hygiene during the observations at breakfast and medication administration earlier in the day. ULP-K stated her handwashing "was lacking" when cooking breakfast for R5 and while taking care of R8. ULP-K stated there was too much going on to complete hand washing. ULP-K stated she would typically wash hand between "all of my tasks," between residents, between going to and from the kitchen to the storeroom or when she assisted a resident in any way while in the middle of cooking. ULP-K stated she had training on infection control and that handwashing was an important skill related to good infection control.</p> <p>On January 19, 2023, at 9:05 a.m., registered nurse (RN)-A stated ULP-K was an experienced</p>	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 10</p> <p>staff, was trained regarding proper infection control and handwashing, but thought ULP-K was nervous. RN-A stated staff should wash hands between residents and should perform hand hygiene anytime between tasks, such as when making food, after touching their phone, handling keys or assisting another resident.</p> <p>ULP-K's education transcript indicated ULP-K received training in infection control techniques, including handwashing, on December 27, 2023.</p> <p>The licensee's Hand Washing policy, dated February 21, 2020, indicated proper handwashing techniques should be used to protect the spread of infection and directed that hand washing shall be performed by all employees, as necessary between tasks, procedures and after bathroom use to prevent cross-contamination. The policy identified when hand washing is to be done, which included before, during and after preparing food and if gloves are used, before donning gloves and after removing gloves.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 510		
0 660 SS=D	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	<p>Continued From page 11</p> <p>and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and ensure employee tuberculosis screening was conducted timely for one of three employees (unlicensed personnel (ULP)-K).</p> <p>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).</p> <p>The findings include:</p> <p>The Facility TB Risk Assessment dated August 30, 2022, indicated the facility was at a low risk for transmission.</p> <p>ULP-K was hired December 26, 2022, and provided direct cares for residents of the facility.</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	<p>Continued From page 12</p> <p>On January 18, 2023, at 7:35 a.m., the evaluator observed ULP-K administer medications to R8.</p> <p>ULP-K's employee record of baseline tuberculin skin test (TST) and symptom and history screening was dated January 19, 2023, and was completed during the survey.</p> <p>On January 19, 2023, at 2:52 p.m., assistant regional director of operations/licensed assisted living director (ADOR/LALD)-B stated TB screening for staff was to be done during the first week of employment, ideally on day one, and the screening would include both the history and symptoms screening and the 1st step of the Mantoux. ADOR/LALD-B stated ULP-K's screening and testing "should have been done" and was not completed timely.</p> <p>The licensee's Tuberculosis & Staff Screening policy, revised August 31, 2022, indicated the licensee's staff whose essential job functions require work within the same air space of residents shall be screened and tested for tuberculosis prior to the staff being exposed to residents. The policy directed new staff shall be screened for active TB using the baseline TB Screening Tool for healthcare workers and shall have a two-step Mantoux conducted with results documented on the TB screening tool. Further, no staff shall be permitted to begin work where the worker involved sharing the air space with resident until the negative results of the first Mantoux are read and documented.</p> <p>The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 13 infection. Further, an employee may begin working with patients after a negative TB symptoms screen and negative IGRA (Interferon-Gamma Release Assays, blood test to diagnose TB) or first step TST (tuberculin skin test) dated within 90 days before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 14</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to review its emergency preparedness plan, or practice and document testing of its plan at least twice annually as required. In addition, the licensee failed to evaluate/revise its missing person policy at least quarterly. This had the potential to affect all 16 residents receiving services under the assisted living with dementia care license, staff and visitors of the facility.</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on January 17, 2023, at 10:17 a.m., the evaluator requested to view the facility's emergency plan and related documentation, which was later provided.</p> <p>EMERGENCY PLAN TESTING AND DOCUMENTATION</p> <p>The evaluator reviewed the facility's emergency preparedness (EP) plan, dated August 2021, and accompanying documents. The EP plan lacked evidence the licensee tested its EP plan and conducted and/or participated in any full-scale</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 15</p> <p>facility drill or tabletop exercise to test its plan and document the results of testing at least twice annually.</p> <p>On January 19, 2023, at 2:55 p.m., assistant regional director of operations/licensed assisted living director(ARDO/LALD)-B stated the testing of the emergency plan, "was not getting done."</p> <p>REVIEW OF MISSING PERSON POLICY</p> <p>The evaluator reviewed the licensee's Missing Resident policy, revised September 4, 2022. Documentation noted on the plan indicated the policy was reviewed on the following dates: February, 20, 2020, June 14, 2022, and September 4, 2022. The licensee's plan and policy lacked evidence the licensee reviewed or updated the policy at least quarterly as required.</p> <p>On January 19, 2023, at 2:55 p.m., ARDO/LALD-B addressed the missing person policy and the required documentation of its review and stated, "I want to say it probably has not been reviewed quarterly."</p> <p>The licensee's Disaster Plan and Emergency Preparedness, Training and Testing Program policy, dated August 1, 2021, indicated for the purposes of the emergency preparedness plan, facility-wide drills involving staff/residents/community person. Etc., will be documented in the emergency preparedness book and made available to surveyors for the purpose of reviewing compliance.</p> <p>The licensee's Missing Resident policy, revised September 4, 2022, indicated the licensee will conduct a thorough search to locate a missing resident. The policy indicated under #12: The</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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 licensee will review this policy annually and any individual resident plans that pertain to elopement, at least quarterly, and all changes will be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 17</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with 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.</p> <p>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).</p> <p>Findings include:</p> <p>A record review and interview were conducted on January 19, 2023, at approximately 10:30 a.m. with Registered Nurse (RN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.</p> <p>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. During interview, RN-A verified that the fire safety and evacuation plan for the facility</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 18</p> <p>lacked or could not provide these provisions.</p> <p>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, RN-A verified that the fire safety and evacuation plan for the facility lacked or could not provide these provisions.</p> <p>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. During interview, RN-A verified that the fire safety and evacuation plan for the facility lacked or could not provide these provisions.</p> <p>Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan at initial hire and twice per year thereafter. During interview, RN-A stated the licensee did not have documentation or a policy on employee training of the fire safety and evacuation plan.</p> <p>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 to include movement, evacuation, or relocation as required by statute. During interview, RN-A stated that the facility did not have documentation or a policy on offering resident training of the fire safety and evacuation plan.</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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 19 Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the licensee had conducted only one drill that did not indicate any sort of evacuation provisions were conducted by the employees as required. No further drill documentation was provided. During interview, RN-A 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		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 950	<p>Continued From page 20</p> <p>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document on the assisted living contract that a resident either listed or declined to name a designated representative for one of three residents (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's service plan dated June 17, 2022, indicated services included assistance with activities of daily living, mobility and locomotion, transfers, medication management, bathing, dressing, bed mobility, medication and treatment management, housekeeping, and laundry services.</p> <p>On January 17, 2023, at 4:58 p.m., the evaluator observed unlicensed personnel (ULP)-F and</p>	0 950		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
0 950	<p>Continued From page 21</p> <p>ULP-G transfer R1 from bed into his wheelchair using a mechanical, standing lift.</p> <p>R1's Resident Lease and Services Agreement, signed by R1 on August 25, 2021, included the "Right to Designate a Representative for Certain Purposes" form, with the required language. R1's agreement did not list a designated representative, and the box to initial, if resident declined to name a designated representative, was left blank.</p> <p>On January 18, 2023, regional director of operations (RDO)-L reviewed R1's signed contract and said it was not complete. RDO-L stated the resident needed to either list a designated representative or initial the box and R1's was missed.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 950		
01060 SS=F	<p>144G.52 Subd. 9 Emergency relocation</p> <p>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <p>(1) the reason for the relocation;</p> <p>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01060	<p>Continued From page 22</p> <p>(3) contact information for the Office of Ombudsman for Long-Term Care;</p> <p>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and</p> <p>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</p> <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <p>(1) the resident, legal representative, and designated representative;</p> <p>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</p> <p>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</p> <p>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation to three of three residents (R5, R6, R7). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care as required of R6 and R7's emergency relocations lasting more than four days.</p> <p>This practice resulted in a level two violation (a</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01060	<p>Continued From page 23</p> <p>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).</p> <p>The findings include:</p> <p>R5 R5 was admitted to the facility on July 5, 2021, with diagnoses including hypertension, peripheral neuropathy, chronic kidney disease, and chronic low back pain.</p> <p>R5's service plan dated June 17, 2022, indicated services included assistance with activities of daily living, mobility, assistance with transfers, medication management, housekeeping, and laundry services.</p> <p>R5's progress notes from November 18, 2022 through December 31, 2022, indicated: -on November 21, 2022, "Client has been admitted to the med/surg [medical/surgical] floor for a UTI [urinary tract infection]. Writer called and spoke to nursing staff at the hospital this AM and reviewed medications as well." -on November 23, 2022, "[R5] returned via private van at about 11:30 a.m."</p> <p>Although relocated away from the facility from November 21, 2022, to November 23, 2022, R5's record lacked evidence notice of emergency relocation was provided to the resident.</p> <p>R6 R6 was admitted to the facility on November 11, 2011, with diagnoses including osteoarthritis,</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01060	<p>Continued From page 24</p> <p>lumbar stenosis, Alzheimer's disease, type 2 diabetes, hypertension, hypothyroid, and depression.</p> <p>R6's service plan dated October 25, 2022, indicated services included assistance with activities of daily living, assistance with transfers, medication and treatment management, housekeeping, and laundry services.</p> <p>R6's progress notes from October 15, 2022, through October 31, 2022, indicated: -on October 25, 2022, "Client returned from hospital after a fall with pelvic fracture on 10/20/22. Client returned at 11:50 a.m., and requires a Hoyer [brand name of a full-body, mechanical] lift for transfers."</p> <p>Although relocated away from the facility from October 20, 2022, to October 25, 2022, R6's record lacked evidence a notice of emergency relocation was provided to the resident/representative or to the Ombudsman following R6's absence of more than four days.</p> <p>R7 R7 was admitted to the facility on March 10, 2022, with diagnoses including urinary tract infection, atrial fibrillation, type 2 diabetes, hypertension, hyperlipidemia, hypothyroidism, chronic obstructive pulmonary disease, and osteoporosis.</p> <p>R7's service plan dated June 26, 2022, indicated services included assistance with activities of daily living, toileting, repositioning, transferring, medication and treatment management, housekeeping, and laundry services.</p> <p>R7's progress notes from November 15, 2022,</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01060	<p>Continued From page 25</p> <p>through December 15, 2022, indicated: -on November 29, 2022, "Resident very lethargic and pale. Laying in bed and only responding to yes/no questions. Resp [respirations] even and non-labored. Denies any pain. Spoke with daughter, re: decline in condition and she was agreeable to sending resident to ED [emergency department] for an eval [evaluation]." -on November 30, 2022, "Resident is still at the hospital and is currently in telemetry. They are still doing test [sic] with no plan for discharge at this time." -On December 5, 2022, "Resident returned from Alomere [hospital] at 2:17 p.m. via w/c [wheelchair] and MediVan [transportation company]."</p> <p>Although relocated away from the facility from November 29, 2022, to December 5, 2022, R7's record lacked evidence a notice of emergency relocation was provided to the resident/representative or to the Ombudsman following R7's absence from the facility of more than four days.</p> <p>R5, R6, and R7's records lacked evidence the licensee delivered a required notice to the resident, legal representative, and designated representative (or to the Office of Ombudsman for Long-Term Care when the resident had not returned to the facility within four days for R6 and R7) to indicate the resident was relocated due to an emergent health care need. The licensee failed to provide to the resident or representative a written notice that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01060	<p>Continued From page 26</p> <p>for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</p> <p>On January 19, 2023, at 5:21 p.m., regional director of operations (RDO)-C stated they had not been providing the emergency relocation notices when residents were, for example, sent to the hospital. RDO-C stated he "was not sure" about the requirement and had not seen this citation made at other locations. RDO-C also stated they have not informed the Ombudsman if a resident was gone from the facility longer than four days. RDO-C stated, "This is new."</p> <p>The licensee's Emergency Relocation policy, effective July 19, 2021, indicated the licensee may remove a resident from the facility in an emergency due to a resident's urgent medical needs or imminent risk the resident poses to the health or safety of another resident or staff member, and the emergency relocation is not a termination. The policy indicated the licensee will provide a written notice of the emergency relocation that contained the items identified above.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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 27	01370		
01370 SS=D	<p>144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn</p> <p>(a) Training and competency evaluations for all unlicensed personnel must include the following:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 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 	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 28</p> <p>emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure demonstrated competency evaluations were completed in all required skill areas for one of two employees (unlicensed personnel (ULP)-K).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-K started employment December 26, 2022, to provide direct care and assisted living services for the licensee's residents.</p> <p>On January 18, 2023, at 7:47 a.m., the evaluator observed ULP-K provide direct care services with activities of daily living for R8 and later administer medications to R8.</p> <p>ULP-K's employee record lacked evidence of demonstrated skill competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic</p>	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 29</p> <p>devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them;</p> <p>On January 19, 2023, at 3:34 p.m., assistant regional director of operations/licensed assisted living director (ADOR/LALD)-B stated she understood unlicensed staff can provide services if they are trained and competency tested. ADOR/LALD-B said they used EduCare (a computer-based training program) for much of the training, and then unlicensed staff are trained by the RN, then follow other aides to learn and practice skills, but then later demonstrate competency to the RN. ADOR/LALD-B said this staff person (ULP-K) needed and should have completed all the required competencies and that should be documented in the employee's file.</p> <p>The licensee's Training and Competency Evaluations for Unlicensed Personnel policy, dated as reviewed September 4, 2022, indicated when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy indicated training and competency evaluations of ULPs would include the tasks identified and listed above.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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 30	01380		
01380 SS=D	<p>144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn</p> <p>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:</p> <ol style="list-style-type: none"> (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. <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure demonstrated competency evaluations were completed in all required skill areas for one of two employees (unlicensed personnel (ULP)-K).</p> <p>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).</p>	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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	<p>Continued From page 31</p> <p>The findings include:</p> <p>ULP-K started employment December 26, 2022, to provide direct care and assisted living services for the licensee's residents.</p> <p>On January 18, 2023, at 7:47 a.m., the evaluator observed ULP-K provide direct care services with activities of daily living for R8 and later administer medications to R8.</p> <p>ULP-K's employee record lacked evidence of demonstrated skill competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning.</p> <p>On January 19, 2023, at 3:34 p.m., assistant regional director of operations/licensed assisted living director (ADOR/LALD)-B stated she understood unlicensed staff can provide services if they are trained and competency tested. ADOR/LALD-B said they used EduCare (a computer-based training program) for much of the training, and then unlicensed staff are trained by the RN, then follow other aides to learn and practice skills, but then later demonstrate competency to the RN. ADOR/LALD-B said this staff person (ULP-K) needed and should have completed all the required competencies and that should be documented in the employee's file.</p> <p>The licensee's Training and Competency Evaluations for Unlicensed Personnel policy, dated as reviewed September 4, 2022, indicated when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the unlicensed</p>	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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 personnel is trained in the proper methods to perform the tasks or procedures and are able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy indicated training and competency evaluations of ULPs would include the tasks identified and listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the pharmacy label for scheduled medication matched the prescriber's order for one of one resident (R8) who received medication delivered via nebulizer.	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01760	<p>Continued From page 33</p> <p>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).</p> <p>The findings include:</p> <p>R8's diagnoses included agitation, dementia, anxiety disorder, early onset Alzheimer's disease, and Covid-19.</p> <p>R8's service plan and medication management plan, each dated June 16, 2022, indicated R8 received services including medication management.</p> <p>R8's prescriber's orders included Albuterol solution 2.5 mg (milligrams)/3 ml (per 3 milliliters) inhale 1 vial twice a day before meals at 8:00 a.m. and 4:30 p.m., for cough.</p> <p>On January 18, 2023, at 7:50 a.m., the evaluator observed unlicensed personnel (ULP)-K set up and prepare R8's nebulizer medication. ULP-K read the label on the box and compared it to the instructions on the medication administration record (MAR) on ULP-K's phone. The pharmacy label on the medication directed inhale contents of one vial in nebulizer every 4 hours as needed for cough/shortness of breath. Those instructions did not match the directions on the MAR which indicated the medication was scheduled and ordered twice daily, at 8:00 a.m. and 4:30 p.m., but not as needed. ULP-K administered the</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01760	<p>Continued From page 34</p> <p>Albuterol medication to R8.</p> <p>On January 18, 2023, at 10:11 a.m., ULP-K verified the instruction for R8's nebulizer did not match the prescription on the box containing the medication. ULP-K said she should have notified and checked with the nurse to make certain the order for the Albuterol on the MAR was correct. ULP-K also said it was likely R8's order had changed but was not updated on the medication package. ULP-K stated she usually did not work R8's unit, was not as familiar with the residents and was still trying to figure out the routine.</p> <p>On January 19, 2023, at 8:59 a.m., registered nurse (RN)-A stated if a resident's order changes and a medication required a new label, they would send the information to the pharmacy who would sent a new label or nursing could put a change of direction label on the box. RN-A stated this "should have been done" and also said if staff administers medication, the pharmacy label and the instruction in the MAR need to match.</p> <p>The licensee's Oral Medications policy, reviewed September 4, 2022, indicated only properly trained staff may provide medication assistance or administration. The policy indicated medications always need to be administered according the "6 Rights:" the right person, medication, time, route, dose and chart/record. Further, the policy directed to compare the information of the MAR with the label on the medication container, and if the MAR and label do not all say the same thing, stop and call the nurse for instructions; the directions on the label and the MAR should be the same.</p> <p>No further information was provided.</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
01760	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02350 SS=E	<p>144G.91 Subd. 7 Courteous treatment</p> <p>Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a dignified dining experience for one of one resident (R8). In addition, the licensee failed to ensure one of one resident (R1) was treated with dignity and respect when R1's urinary collection bag was uncovered in the common area of the facility.</p> <p>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).</p> <p>The findings include:</p> <p>LACK OF DIGNIFIED DINING EXPERIENCE</p> <p>R8's diagnoses included agitation, dementia, anxiety disorder, and early onset Alzheimer's disease.</p> <p>R8 Service plan dated June 17, 2022, indicated</p>	02350		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
02350	<p>Continued From page 36</p> <p>R8 received services including assistance with activities of daily living, eating, mobility, transfers, medication management, laundry, and housekeeping.</p> <p>On January 18, 2023, at 8:11 a.m., unlicensed personnel (ULP)-K wheeled R8 from his room to the kitchen/dining area for the breakfast meal and positioned R8 at a table with the resident's back to the fireplace and facing the entry way. R8 waited at the table and was not served until ULP-K began feeding R8 oatmeal at 8:55 a.m., 40 minutes later. The evaluator observed ULP-K standing up to feed R8, directly in front of the resident, dishing a spoonful of oatmeal and lowering it into R8's mouth. Between bites, ULP-K left R8 unattended and bussed other residents' dishes. ULP-K resumed feeding and after a few more bites, ULP-K left the dining area to place a bandage on her finger. When R8's oatmeal was nearly finished, ULP-K prepared a glass of grape juice for R8 and brought it to the table. ULP-K again left the table and R8 unattended, and another resident wandered into the dining area, sat down next to R8 and began to drink R8's glass of juice.</p> <p>On January 18, 2023, at 10:15 a.m., ULP-K said it was not dignified to be running back and forth between residents to try to make breakfast and feed them. ULP-K said she would like to sit next to R8 while feeding and focus only on one person. ULP-K added, "That would be a reason to have more staff available for meals."</p> <p>During the noon meal on January 18, 2023, at 12:54 p.m., the evaluator observed ULP-D feed R8 and noted ULP-D fed the resident while standing up in front of him. ULP-D fed R8 several bites, then left the resident unattended before</p>	02350		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
02350	<p>Continued From page 37</p> <p>resuming feeding, either to attend to other residents at the table or to do kitchen chores. ULP-D fed R8 his entire meal and beverage, standing up next to the resident.</p> <p>On January 18, 2023, at 2:13 p.m., ULP-D stated she routinely fed R8, and other "feeders" while standing up. ULP-D stated she had to do it to keep going and get everyone fed. ULP-D stated standing was the only way they can get feeding done for more residents in the time allotted, adding that she had complained about needing extra staff, especially during mealtime. ULP-D stated, "I do feel bad about it" and, "I think we need to do more on what the residents need rather that focus on getting tasks done."</p> <p>On January 19, 2023, at 9:08 a.m., registered nurse (RN)-A stated when feeding a resident, after washing hands and placing a clothing protector, she would expect staff be seated next to the resident, allowing engagement with eye contact, conversation, with continuous observation to ensure the resident is chewing, swallowing, and not pocketing food. RN-A stated feeding a resident while standing "is not a dignified experience."</p> <p>On January 19, 2023, at 2:38 p.m., assistant regional director of operations/licensed assisted living director (ADOR/LALD)-B stated that during meals, staff were to sit down next to the resident they are assisting, make eye contact, have conversation, alternate foods and drinks, and engage the resident as much as possible. Later at 3:37 p.m., when the evaluator inquired about a policy, ADOR/LALD-B stated they did not have a "dignity" policy, but said staff were educated using EduCare (computer-based learning) about how to talk to and treat residents with dementia and</p>	02350		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
02350	<p>Continued From page 38</p> <p>really all residents. LALD/RN-B stated they had the bill of rights, which was how they expected staff to treat residents. Regional director of operations (RDO)-C stated he was involved in educating staff with person-centered care, and said that assisting someone with eating while standing up was "not in the curriculum."</p> <p>URINARY COLLECTION BAG UNCOVERED</p> <p>R1's diagnoses included sacral spinal bifida (birth defect in which an area of the spinal column is improperly formed) and neurogenic bladder.</p> <p>R1's service plan, dated June 17, 2022, indicated services included assistance with activities of daily living, mobility and locomotion, transfers, medication management, bathing, dressing, bed mobility, medication and treatment management, housekeeping, and laundry services.</p> <p>On January 17, 2023, at 11:50 p.m., the evaluator was seated at a table in the "Link," an open room, approximately 25' (feet) wide and 50" in length which connected the two main sections of the facility, the Lake Henry and Lake Agnes Suites. The evaluator observed staff and visitors walk from Lake Henry Suites through the Link to Lake Agnes suites side of the building and vice versa. At 12:00 p.m., R1, seated in a wheelchair, entered the link from the Lake Agnes Suites. The evaluator observed an uncovered, urine collection bag hanging under R1's wheelchair, partially filled with urine. The evaluator asked about the catheter bag and R1 stated "it doesn't bother me" adding that the bag has been in place "for as long as I've had a catheter, for many, many years." R1 stated when he went out of the facility, they would put a leg bag on so the collection would be hidden, but added, "I never thought" the</p>	02350		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIAMOND WILLOW OF ALEXANDRIA	STREET ADDRESS, CITY, STATE, ZIP CODE 803 VICTOR STREET ALEXANDRIA, MN 56308
---	--

(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
02350	<p>Continued From page 39</p> <p>uncovered bag may bother someone else. R1 stated he's never had the larger collection bag be covered when in use. R1 also stated he frequently wheeled out to the Link and spent time out of his room with the larger collection bag in place. Later at 5:12 p.m., R1 was seated at the Lake Agnes Suites dining table and the uncovered collection bag was under R1's wheelchair.</p> <p>On January 18, 2022, at 12:44 p.m., the evaluator observed R1 seated in common area dining room of the Lake Agnes Suites eating the noon meal. The evaluator observed a urine collection bag under R1's wheelchair. Following the noon meal at 1:20 p.m., R1 was seated in his wheelchair in the Link common area and the urine collection bag was visible under R1's wheelchair. At 5:47 p.m., the evaluator observed R1 again seated in his wheelchair at the Lake Agnes Suites dining room table during the evening meal. The catheter collection bag, observed with urine, was underneath R1's wheelchair and uncovered.</p> <p>On January 19, 2023, at 9:11 a.m., RN-A stated R1's collection bag should be covered and said it was a dignity issue. RN-A stated maybe it did not bother R1, "but it may not be what others want to see."</p> <p>On January 19, 2023, at 2:37 p.m., ADOR/LALD-B stated the licensee purchased catheter bag covers for their other facilities and thought "all of our facilities" had done so as well.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02350		



Type: Full
Date: 01/18/23
Time: 22:15:54
Report: 1008231001

Food and Beverage Establishment Inspection Report

Location:

Diamond Willow Of Alexandria
803 Victor Street
Alexandria, MN56308
Douglas County, 21

Establishment Info:

ID #: 0037715
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207621448
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.13

**** Priority 1 ****

MN Rule 4626.0245 Discontinue use of unpasteurized eggs or egg products in the preparation of food such as Caesar salad, hollandaise or bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages, and other foods that are not cooked as specified in 4626.0340.

NON PASTEURIZED EGGS WERE STORED IN COOLER. DISCUSSION WITH KITCHEN STAFF AS TO HOW EGGS ARE USED WITHIN ESTABLISHMENT. DISCONTINUE TO USE NON PASTEURIZED EGGS WITH A HIGHLY SUSCEPTIBLE POPULATION.

Comply By: 01/19/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CURRENTLY ESTABLISHMENT HAS NO CFPM. SEND A EMPLOYEE TO AN APPROVED CFPM COURSE.

Comply By: 02/18/23

2-400 Hygienic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

EMPLOYEES HAD OPEN BEVERAGE CUPS WITHIN THE FOOD PREPARATION/KITCHEN AREA. EMPLOYEE BEVERAGE CONTAINERS SHALL HAVE COVERS WHEN IN THE FOOD PREPARATION/KITCHEN AREA.

Comply By: 01/19/23

Type: Full
Date: 01/18/23
Time: 22:15:54
Report: 1008231001
Diamond Willow Of Alexandria

Food and Beverage Establishment Inspection Report

Page 2

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

MOTION SENSORS WITH BATTERIES WERE CURRENTLY BEING STORED IN DRY STORAGE ROOM ON TOP OF SHORTENING. SEPARATE FOOD AND STORAGE OF NON FOOD ITEMS. RELOCATE THE MOTION SENSORS.

Comply By: 01/19/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC KITCHEN. KITCHEN IS BEING USED AS A COMMERCIAL KITCHEN WITH COOKING, COOLING, REHEATING, COLD HOLDING. WITHOUT A COMMERCIAL KITCHEN ALL TCS FOODS SHALL BE CATERED IN FOR ALL MEALS OR ONLY HELD WITHIN THE ESTABLISHMENT FOR A MAX OF 24 HOURS.

Comply By: 02/17/23

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COULD NOT FIND A THERMOMETER IN THE REFRIGERATORS IN EITHER OF THE DRY STORAGE ROOMS. PROVIDE A THERMOMETER IN THE BOTTOM/COOLER PART OF THESE REFRIGERATORS.

Comply By: 01/25/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE OVEN IN THE SOUTH KITCHEN HAS A SIGN ON IT "DO NOT USE OVEN PART". THERE WAS A DISCUSSION WITH KITCHEN STAFF REGARDING THIS SIGN. THE OVEN DOES NOT WORK PROPERLY. REPAIR OR REPLACE THIS OVEN.

Comply By: 02/17/23

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 40 Degrees Fahrenheit - Location: PUDDING - SOUTH KITCHEN

Violation Issued: No

Type: Full
Date: 01/18/23
Time: 22:15:54
Report: 1008231001
Diamond Willow Of Alexandria

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: CARROTS - SOUTH KITCHEN DRY STORAGE
COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: PUDDING - NORTH KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: EGGS - NORTH KITCHEN DRY STORAGE
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	0	6

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

Type: Full
Date: 01/18/23
Time: 22:15:54
Report: 1008231001
Diamond Willow Of Alexandria

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1008231001 of 01/18/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Signed: emailed to HRD
Establishment Representative

Signed: Inspector ID# 1008

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us