Electronically Delivered

December 29, 2025

Licensee
Diamond Willow Assisted Living
1558 Randolph Road
Detroit Lakes, MN 56501

RE: Project Number(s) SL25380016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25380	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1558 RANDOLPH ROAD DETROIT LAKES, MN 56501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25380016-0 On December 8, 2025, through December 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 22 residents; 22 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 485		

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0 485	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 8, 2025, at 9:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. On December 8, 2025, at 9:31 a.m., LALD/LPN-A stated the license included payment for three meals per day as part of the assisted living contract. On page three of the (licensee name) Resident Lease and Services Agreement (assisted living contract) dated March 4, 2024, section: B. Included Services indicated three (3) nutritionally well balanced meals and snacks each day were included in the monthly base rent. The licensee's Addendum A (to the assisted living contract) dated March 4, 2025, indicated three (3) nutritionally well balanced meals and snacks each day were included in the base rate constituting rent. Resident assisted living contracts lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On December 9, 2025, at 10:02 a.m., LALD/LPN-A stated the licensee was not aware the licensee could not include and pay for three meals as part of their assisted living contract. On December 9, 2025, at 10:33 a.m., LALD/LPN-A stated corporate management was	0 485		

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0 485	Continued From page 5 in the process of updating the licensee's assisted living contract to not include residents paying for three meals per day as part of the assisted living contract. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during medication administration	0 510		

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0 510	Continued From page 6 for two of five employees (unlicensed personnel (ULP)-F, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on December 8, 2025, at 9:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents at the facility. ULP-F On December 9, 2025, at 7:09 a.m., the surveyor observed ULP-F put on gloves, place R5's medications into a plastic cup, locked the medication cart, removed ULP-F's gloves, and administered R5's oral medications. ULP-F returned to the computer to document R5's medication administration and went to the kitchen to pour a cup of coffee for a resident. The surveyor did not observe ULP-F complete hand hygiene before or after putting on and removing gloves. Immediately following the observation, ULP-F stated ULPs were trained to complete hand hygiene before putting on gloves and after taking gloves off. ULP-E On December 9, 2025, at 7:30 a.m., the surveyor	0 510		

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0 510	Continued From page 7 observed ULP-E administer R2's scheduled insulin, ULP-E removed ULP-E's gloves, returned to the computer to document the administration of R2's insulin, ULP-E put on a new pair of gloves, and went to the kitchen to pour a glass of orange juice for a resident. The surveyor did not observe ULP-E complete hand hygiene in between glove changes. On December 10, 2025, at 9:59 a.m., ULP-E stated ULP-E received infection control training upon hire and ULP-E was trained to complete hand hygiene before putting on gloves and after removing gloves. On December 10, 2025, at 12:12 p.m., clinical nurse supervisor (CNS)-B stated ULPs were expected to complete hand hygiene before putting on gloves and immediately after removing gloves. LALD/LPN-A stated ULPs received infection control training upon hire and annually thereafter. The licensee's 8.07 Gloves policy dated January 1, 2025, indicated to wash hands before applying gloves and after removal of gloves. The licensee's 8.14 Standard Precautions policy dated January 1, 2025, indicated hand should be washed or sanitized after removing gloves and after any direct contact with body secretions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 8 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 660		

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0 660	Continued From page 9 The findings include: During the entrance conference on December 8, 2025, at 9:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on November 11, 2025, and the facility was determined to be a low risk level. CNS-B was hired on October 22, 2025, to provide direct care services to residents and supervision to the staff at the assisted living facility. Throughout the survey on December 8, 2025, through December 10, 2025, the surveyor observed CNS-B provide direct care to residents and supervised staff at the assisted living with dementia care facility. CNS-B's employee record contained a negative TB screen dated October 27, 2025, and a negative blood test collected on April 7, 2025 (198 days prior to CNS-B's employment start date). In addition, CNS-B's employee record contained a negative TB screen dated December 2, 2025, and a negative first-step TST dated December 5, 2025. CNS-B's employee record lacked evidence of a two-step TST or other evidence of a TB screening such as a blood draw within 90 days of employment or upon hire. On December 9, 2025, at 10:14 a.m., LALD/LPN-A stated LALD/LPN-A had thought the	0 660		

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0 660	Continued From page 10 licensee accepted TB blood draws if the blood draw was completed within one year from employment start date. LALD/LPN-A further stated the licensee had completed a first-step mantoux for CNS-B on December 5, 2025. On December 10, 2025, at 10:28 a.m., CNS-B stated a first-step mantoux had been completed, however, CNS-B should have had a two-step mantoux upon hire. The licensee's 8.16 TB Screening policy dated January 1, 2025, indicated staff whose essential job functions require work within the same air space of residents will be screened and tested for TB prior to the staff being exposed to clients (residents). New staff will have an IGRA (Interferon-Gamma Release Assay) blood test or a two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool for HCWs. The policy did not address acceptance of an employee's previous TB blood draw. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last October 13, 2025, indicated a licensee could accept a TST or IGRA blood test dated within 90 days of hire for a new	0 660		

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0 660	Continued From page 11 employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=C	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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 12 licensee failed to ensure the missing resident policy was reviewed quarterly. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 8, 2025, at 9:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated Emergency Preparedness Plan (EPP) included a 2.28 Missing Resident policy dated January 1, 2025. The licensee's EPP provided did not include a quarterly review of the Missing Resident policy. On December 9, 2025, at 10:07 a.m., LALD/LPN-A stated the licensee reviewed the missing resident policy at least every six months, however, was not aware the missing resident policy was supposed to be reviewed on a quarterly basis. On December 10, 2025, at 11:43 a.m., LALD/LPN-A stated LALD/LPN-A was unable to locate documentation of how often the missing resident plan was reviewed by the licensee. The licensee's 2.28 Missing Resident policy dated January 1, 2025, indicated (licensee name) will	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25380	A. BUILDING: _____ B. WING _____	12/10/2025

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0 680	Continued From page 13 review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 14 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for one of two residents (R2). In addition, the licensee failed to ensure the resident record included a discharge summary with all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 730		

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0 730	Continued From page 15 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 9:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. DOCUMENTATION OF SERVICES PROVIDED R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and cerebral infarction (ischemic stroke). R2's Service Plan- Modification dated October 6, 2025, indicated R2's services included medication administration, bathing, grooming, dressing, toileting, transfers, recording output, and housekeeping. On December 9, 2025, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R2's scheduled morning medication. R2's Treatment Recap Summary- Monthly dated November 2025, indicated the following: -November 5, 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 12:00 a.m.; -November 5, 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 3:00 a.m.; -November 4, and 5, respectively, indicated R2	0 730		

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0 730	Continued From page 16 did not receive catheter care at 5:45 a.m.; -November 5, 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 6:00 a.m.; -November 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 9:00 a.m.; -November 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 12:00 p.m.; -November 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 3:00 p.m.; -November 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 6:00 p.m.; -November 6 indicated R2 did not receive catheter care at 8:00 p.m.; and -November 6, 8, 12, 13, 14, 15 ,16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30, respectively, indicated R2 did not have output recorded at 9:00 p.m. R2's records lacked documentation of the services noted above, or the reason why the service was not provided to R2. On December 10, 2025, at 12:24 p.m., LALD/LPN-A stated ULPs were expected to document services after the service was provided to a resident or to document the reason a service was not provided to a resident. LALD/LPN-A further stated R2 was provided the services noted above, however, ULPs did not document the service provided.	0 730		

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0 730	Continued From page 17 DISCHARGE SUMMARY R1's diagnoses included right side hemiplegia (paralysis or severe weakness in one side of the body), hypertension (HTN- high blood pressure), and depression. R1's Service Plan (Waiver)- Addendum to Contract (service plan) dated July 1, 2025, indicated R1 received medication administration, assistance with bathing, grooming, dressing, toileting, transferring, and housekeeping. R1's Discharge/ Transfer Summary dated November 20, 2025, included R1's diagnoses, allergies, finance/care decisions, and R1 was admitted to a skilled nurse facility. R1's discharge lacked evidence of R1's status from last assessment, a reconciliation of all predischarge medications with the resident's postdischarge prescribed and over-the-counter medications, and a postdischarge plan that is developed with the resident or resident's representative that includes any arrangements that have been made for the resident's follow-up care, and any postdischarge medical and nonmedical services the resident will need. On December 8, 2025, at 2:07 p.m., LALD/LPN-A stated R1's record lacked the required documentation for a discharge, however, the licensee was aware of the requirement. LALD/LPN-A further stated the previous registered nurse (RN) had quit the licensee the same day R1 was discharged, and the discharge paperwork was not completed as required. The licensee's 2.38 Resident Record- Information and Content policy dated January 1, 2025,	0 730		

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0 730	Continued From page 18 indicated resident records included documentation that services have been provided as identified in the service plan. In addition, the resident record would include a discharge summary, including service termination notice and related documentation, when applicable. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 19 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810		

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0 810	Continued From page 20 Environment Inspection Report (PEIR) dated December 08, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a resident or resident	01640		

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01640	Continued From page 21 representative's signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 9:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. R6's diagnoses included diabetes, fracture of the neck, and dementia. On December 9, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R6's scheduled morning medication. R6's Service Plan (Waiver)- Addendum to Contract (service plan) dated December 9, 2025 (one day after survey entrance), did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On December 9, 2025, at 11:28 a.m., registered nurse (RN)-D stated the licensee was not able to	01640		

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01640	Continued From page 22 locate a signed service plan for R6. RN-D further added the service plan was supposed to be signed by the resident or resident's representative along with a signature from the licensee agreeing upon services to be provided within the first 14 days of services and for any changes made to the service plan. The licensee's 6.08 Service Plan policy dated January 1, 2025, indicated the service plan and any revisions shall include a signature or other authentication by (licensee name) and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of the administration of medications included all required content for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 9:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents at the facility. R6's diagnoses included diabetes, fracture of the neck, and dementia. R6's Service Plan (Waiver)- Addendum to Contract (service plan) dated December 9, 2025, indicated services included medication administration four times per day. R6's prescriber orders dated July 24, 2025, included an order for Novolog Flexpen insulin 100 units/milliliter (mL) to be administered three times daily at 8:00 a.m., 12:00 p.m., and 5:00 p.m. per the below sliding scale (a scale directing the amount of insulin that should be administered	01760		

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01760	Continued From page 24 based off the blood glucose (sugar) result): - less than 150 = administer 0 units; - 150 - 199 = administer 1 unit; - 200 - 249 = administer 2 units; - 250 - 299 = administer 3 units; - 300 - 349 = administer 4 units; - 350 - 399 = administer 5 units; - 400 - 449= administer 6 units and notify on call; and - greater than 450 = administer 7 units and notify on call to inform them orders indicate to contact provider (physician). On December 9, 2025, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-E administer 3 units of Novolog insulin to R6 per the sliding scale form R6's blood glucose reading of 250. ULP-E documented on R6's electronic medication administration record (EMAR) R6 was administered 3 units of Novolog Flexpen insulin. R6's Med (medication) Admin (administration) Summary- Month dated November 2025, and December 2025, respectively, indicated the following: -November 2, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -November 13, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -November 21, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -November 23, 2025, at 8:00 a.m., lacked how many units of Novolog Flexpen insulin was administered; -November 26, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered;	01760		

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01760	Continued From page 25 -November 27, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -November 29, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -November 30, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -December 1, 2025, at 5:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -December 4, 2025, at 12:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -December 6, 2025, at 12:00 p.m., lacked how many units of Novolog Flexpen insulin was administered; -December 7, 2025, at 8:00 a.m., lacked how many units of Novolog Flexpen insulin was administered; and -December 8, 2025, at 8:00 a.m., lacked how many units of Novolog Flexpen insulin was administered. On December 10, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated the number of insulin units administered per R6's sliding scale should have been documented each time by ULPs to ensure the correct dosage was administered. LALD/LPN-A stated some ULPs had documented the number of insulin units administered to R6 from the sliding scale under the notes, however, not all ULPs had documented the insulin units under R6's notes. The licensee's 7.22 Medication and Treatment Record- Documentation and Refusal policy dated January 1, 2025, indicated documentation of medication administration included the quantity of	01760		

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	25380	A. BUILDING: _____ B. WING _____	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAMOND WILLOW ASSISTED LIVING	1558 RANDOLPH ROAD DETROIT LAKES, MN 56501

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01760	Continued From page 26 dosage for the medication. The licensee's 7.36 Insulin Administration policy dated January 1, 2025, indicated to document the medication administration, including the time, dose, and any observations in the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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01910	Continued From page 27 licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 9:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents at the facility. The licensee's Discharged or Deceased Resident Roster: Assisted Living dated October 1, 2025, through December 8, 2025, indicated R1 was admitted on June 30, 2025, and was discharged on November 20, 2025, to a skilled nursing home. R1's diagnoses included right side hemiplegia (paralysis or severe weakness in one side of the body), hypertension (HTN- high blood pressure), and depression. R1's Service Plan (Waiver)- Addendum to Contract (service plan) dated July 1, 2025, indicated R1 received medication administration four times per day.	01910		

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01910	Continued From page 28 R1's Med (medication) Admin (administration) Summary dated November 2025, indicated R1 received the following medications: -Lansoprazole (antacid) 30 milligrams (mg) daily -aspirin (anticoagulant) 325 mg daily -barrier cream (skin protectant) applied twice daily -Bupropion (antidepressant) 75 mg daily -Advair (for asthma) 250-50 micrograms (mcg)/actuation (act) one puff daily -folic acid (supplement) 1 mg daily -gabapentin (for nerve pain) 300 mg three times daily -Miralax (for constipation) 17 grams (g) daily -Sucralfate (antacid) 1 g twice daily -vitamin K (for blood clotting) 100 mcg daily -Voltaren (for pain) 1% 4 g twice daily -Jantoven (anticoagulant) 22.5 mg daily -Atorvastatin (for hyperlipidemia) 80 mg daily -Amitriptyline (for nerve pain) 10 mg daily -hydrocodone/APAP (for severe pain) 5 mg/325 mg every six hours as needed R1's prescriber orders dated July 24, 2025, included the above noted medications, however, lacked prescriber orders for vitamin K and Jantoven. R1's record lacked documentation for the disposition of the above medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On December 8, 2025, at 2:07 p.m., LALD/LPN-A stated R1's record lacked the required documentation for medication disposition, however, the licensee was aware of the	01910		

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01910	Continued From page 29 requirement. LALD/LPN-A further stated the previous registered nurse (RN) had quit the licensee the same day R1 was discharged, and medication disposition documentation was not completed, however, LALD/LPN-A had received report from staff, which indicated R1's medications were sent with R1's mother to the skilled nursing home where R1 was admitted. The licensee's 7.23 Medication Disposal policy dated January 1, 2025, indicated current unused medications managed by the licensee will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility, or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the	02040		

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02040	Continued From page 30 assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 08, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02310	Continued From page 31	02310		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R2) with hospital bed rails. In addition, the licensee failed to ensure oxygen was stored safely for one of one oxygen cylinder. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 9:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. BED RAILS R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and cerebral	02310		

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02310	Continued From page 32 infarction (ischemic stroke). R2's Service Plan- Modification dated October 6, 2025, indicated R2's services included medication administration, bathing, grooming, dressing, toileting, transfers, recording output, and housekeeping. On December 8, 2025, at 12:03 p.m., the surveyor observed unlicensed personnel (ULP)-C complete a blood glucose check for R2. During the observation, the surveyor observed upper bilateral hospital bed rails on R2's bed. R2's Assessment dated September 30, 2025, indicated R2 had bilateral upper side rails (bed rails) attached to R2's bed. R2 used the bed rails to reposition, the bed rails were not a restraint or a high risk for injury, R2 did not take any medications that affected R2's mental status, education was provided, risk and benefits were discussed, the bed rails are appropriate based upon the assessed need for R2, and the bed rails met the FDA (Food and Drug Administration) guidelines. In addition, Zone 1 was 2 inches, Zones 2 and 3 were less than 4 ¾ inches, however, the actual measurements documented were zero (0) inches for bed rail zones 2, 3, and 4. R2's record lacked evidence of documentation of the accurate zone measurements for zones 2, 3, and 4 on R2's bed rails. On December 10, 2025, at 12:27 p.m., LALD/LPN-A and registered nurse (RN)-D stated the documentation of R2's bed rails were documented incorrectly, however, R2's bed rails met current FDA requirements. RN-D further stated the actual documentation of inches for	02310		

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02310	Continued From page 33 each bed rail zone was expected to be written in the assessment under the notes section. The licensee's 6.28 Side Rails policy dated January 1, 2025, indicated hospital-type bed rails must be measured according to the FDA's 2006 guidance on dimensional safety, specifically ensuring that the seven safety zones of the bed rail meet the FDA's criteria to reduce entrapment risk. Zones 1, 2, and 3 must not exceed 4.75 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 13, 2025, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and	02310		

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02310	Continued From page 34 - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. OXYGEN STORAGE On December 8, 2025, at 9:09 a.m., the surveyor observed an oxygen cylinder tank sitting up right not stored in a rack or secured located in the link (shared resident space for activities). On December 9, 2025, at 9:59 a.m., LALD/LPN-A stated all oxygen cylinders were to be stored and secured in a cardboard or metal rack located in resident rooms, however, LALD/LPN-A was not sure why the single oxygen cylinder was stored in the link. The licensee's 7.40 Oxygen policy dated January 1, 2025, indicated oxygen cylinders and vessels	02310		

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02310	Continued From page 35 must remain upright at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was	02410		

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02410	Continued From page 36 maintained for one of five residents (R2) during medication management services in a nonprivate area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 9:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents at the facility. On December 9, 2025, at 7:30 a.m., the surveyor observed R2 sitting at the dining room table with other residents seated at the same table. The surveyor observed unlicensed personnel (ULP)-E lift R2's shirt, exposing R2's abdomen, and administered R2's insulin. The surveyor did not observe ULP-E offer to move R2 to a private area to administer R2's insulin or ask R2 if R2 was okay with having R2's insulin administered at the table with other residents present. In addition, the surveyor did not observe ULP-E ask other residents at the dining room table if they were comfortable with having R2's insulin administered at the dining room table. On December 10, 2025, at 9:59 a.m., ULP-E stated ULP-E knew R2 did not mind having insulin administration at the dining room table	02410		

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02410	Continued From page 37 with other residents present and had asked R2 about the preferred medication administration location before. On December 10, 2025, at 12:13 p.m., LALD/RN-A stated any medication administered to a resident that was not oral was supposed to be administered in the resident's room. Clinical nurse supervisor (CNS)-B further stated residents were supposed to be offered a private area for medication administration and if a resident preferred to have medication administration in a shared resident area other residents were supposed to be asked if they were comfortable with the medication administration in the shared area. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, indicated residents have the right to respect and privacy regarding the resident's service plan. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

DIAMOND WILLOW ASSISTED LIVING
1558 RANDOLPH ROAD
Detroit Lakes, MN 56501
Becker County
Parcel:

Phone:

License Info

License: HFID 25380

Risk:
License:
Expires on:
CFPM: Lisa Vogt
CFPM #: FM 125282; Exp: 05/06/2027

Inspection Info

Report Number: F1049251219
Inspection Type: Full - Single
Date: 12/9/2025 Time: 11:20 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: THE CFPM CERTIFICATE WAS NOT POSTED AT THE ESTABLISHMENT. PIC INSTRUCTED TO POST THE CFPM CERTIFICATE AT THE ESTABLISHMENT.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: THE ESTABLISHMENT LACKS A FOOD THERMOMETER. PIC INSTRUCTED TO OBTAIN A FOOD THERMOMETER FOR BOTH KITCHENS.
Comply By: 12/9/2025 Originally Issued On: 12/9/2025

Food & Beverage General Comment

INSPECTOR MET WITH MDH NURSE EVALUATOR, SARA UMLAUF, AND ESTABLISHMENT REPRESENTATIVE.

DISCUSSED THE FOLLOWING:
- MAINTAIN TEMPERATURE LOGS
- MAINTAIN COOLING LOGS
- TRANSPORT FOOD FROM GROCERY STORE IN COOLER BAGS TO MAINTAIN TCS FOODS AT 41 DEGREES F OR BELOW.
- SAME DAY SERVICE REQUIREMENTS (DOMESTIC KITCHEN) VS COOKING, COOLING AND REHEATING REQUIREMENTS (ANSI KITCHEN).

BOTH KITCHENS HAVE TILE FLOORING, WOOD CABINETS WITH LAMINATE COUNTERTOPS, SMOOTH WALLS AND CEILING.

ESTABLISHMENT IS USING THE SECOND KITCHEN'S DISH MACHINE TO SANITIZE DISHES AND UTENSILS. THE DISH MACHINE REACHED THE CORRECT TEMPERATURE REQUIRED BY CODE.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

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 at 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.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Fergus Falls District Office inspection report number F1049251219 from 12/9/2025

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

DIAMOND WILLOW ASSISTED LIVING
Detroit Lakes
County/Group: Becker County

Inspection Info

Report Number: F1049251219
Inspection Type: Full
Date: 12/9/2025
Time: 11:20 AM

Food Temperature: Product/Item/Unit: Rice**; Temperature Process:** Re-Heating
Location: Stove - Kitchen 1 at 155 Degrees F.
Comment: Inspector rechecked the temperature, the rice fully reheated to 169.5 Degrees F.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ham and Bean Soup**; Temperature Process:** Cooling
Location: Upright Cooler - Kitchen 1 at 84.5 Degrees F.
Comment: Establishment started cooling at 11:10 AM. Inspector rechecked the soup at 12:10 PM, the temperature rechecked at 73.5 Degrees F.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Chicken Salad**; Temperature Process:** Cold-Holding
Location: Upright Cooler - Kitchen 1 at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hamburger Patty**; Temperature Process:** Cooking
Location: Oven - Kitchen 2 at 186.5 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ham and Bean Soup**; Temperature Process:** Hot-Holding
Location: Slow Cooker - Kitchen 2 at 158.5 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: 2% Milk**; Temperature Process:** Cold-Holding
Location: Upright Cooler - Kitchen 2 at 38.5 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Chicken Salad**; Temperature Process:** Cold-Holding
Location: Upright Cooler - Kitchen 2 at 41 Degrees F.
Comment:
Violation Issued?: No

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Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

DIAMOND WILLOW ASSISTED LIVING
Detroit Lakes
County/Group: Becker County

Inspection Info

Report Number: F1049251219
Inspection Type: Full
Date: 12/9/2025
Time: 11:20 AM

Sanitizing Chemical: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 161.1 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL25380016-0	**Date:** 12/8/2025
Facility Name: Diamond Willow of Detroit Lakes	
Facility Address: 1558 Roudolph Rd Detroit Lakes	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. **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. [Minn. Stat. 144G.45 subd.2]**

   Comments: *Licensee's evacuation drill log indicated evacuation drills were conducted on July 7,2025 and August 20, 2025. Licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated they were conducting the fire drills every other month for all three shifts but was not able to provide this documentation*.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. **An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]**

   Comments: A review of the safety risk assessment showed global issues such as fire, gas leaks, and epidemics had been identified. Local hazards that are site, building, and population-specific had not been

developed. LALD/LPN-A stated he had not completed the safety risk assessment on and around the facility property.